MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10143

CERTIFICATE OF DEATH

10141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BENEVOLA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BOONSBORO ROUTE 1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BENEVOLA
d. STREET ADDRESS: BOONSBORO ROUTE 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS Middle ELMER Last ALDRIDGE

4. DATE OF DEATH: Month JULY Day 22 Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 24. 1913
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months 7 Days 28
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER
10b. KIND OF BUSINESS OR INDUSTRY: BOONSBORO HIGH SCHOOL
11. BIRTHPLACE (County & State, or foreign country): PITTSBURGH PENNA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT ALDRIDGE
14. MOTHER'S MAIDEN NAME: DORA FURLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 173-03-0043
17. INFORMANT: MRS. RUTH ALDRIDGE — Address: BOONSBORO MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Pancreas — INTERVAL BETWEEN ONSET AND DEATH: July 1965
157X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1967 to July, 1967 that (I) (we) last saw the deceased alive on July 15 1967, and that death occurred at 7:4 M, from causes and on the date stated above.

22a. SIGNATURE: Charles C. Spencer
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-22-67
22c. PHYSICIAN'S NAME (Type): Dr. Charles C. Spencer
22d. ADDRESS: 145 S. Prospect St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JULY. 24. 1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR LAWN PARK
23d. LOCATION (City or Town) (County) (State): NEAR HAGERSTOWN MD.

24. FUNERAL DIRECTOR: John A. Bast Sr. — ADDRESS: BOONSBORO MD

25a. REC'D BY REGISTRAR DATE: JUL 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingst

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10144

CERTIFICATE OF DEATH

10142

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 107 Hunter Hill Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle MICHAEL Last BECKLEY
4. DATE OF DEATH: Month July Day 2 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 17 1900
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10b. KIND OF BUSINESS OR INDUSTRY: Bester- Long
11. BIRTHPLACE (County & State, or foreign country): Md Clear Spring Wash Co
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: J. Ashby Beckley
14. MOTHER'S MAIDEN NAME: Mary V. Speaker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ----
16. SOCIAL SECURITY NO.: 214-09-1159
17. INFORMANT: Frederick H. Beckley Address: Hagerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): multiple pulmonary emboli — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
(b): congestive heart failure — weeks
DUE TO
(c): arteriosclerotic heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200
107 Hunter Hill Drive

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): huge toxic goiter
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 10, 1967, to death, 19__, that (I) (we) last saw the deceased alive on 1 July 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: John C. Stauffer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/5/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md
24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc ADDRESS: Hagerstown Md.
25a. REG'D BY REGISTRAR DATE: JUL 6 1967
25b. REGISTRAR'S SIGNATURE: Florence Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10145

CERTIFICATE OF DEATH

10143

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Hagerstown
c. LENGTH OF STAY IN 1b: 21 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD 3

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Hagerstown
d. STREET ADDRESS: RFD 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Roscoe — Middle: Edwin — Last: Beckley
4. DATE OF DEATH: Month: July — Day: 1, — Year: 19 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 10-16-97
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY: farm
11. BIRTHPLACE (County & State, or foreign country): Washington Co., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David L. Beckley
14. MOTHER'S MAIDEN NAME: May J. Shifler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 219-36-2641
17. INFORMANT: Margaret Beckley, Hagerstown, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
(b): Arteriosclerotic Cardio Vascular Disease — Several years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1, 1967, to July 1, 1967, that (I) (we) last saw the deceased alive on June 14, 19 67, and that death occurred at 1:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: E. W. Ditto — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 7-3-67
22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.
22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-4-67
23c. NAME OF CEMETERY OR CREMATORY: Salem Reformed Cem.
23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home — ADDRESS: Hagerstown, Md.
25a. RECD BY REGISTRAR DATE: JUL 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10146

CERTIFICATE OF DEATH

10144

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Gateway Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Middletown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Esther — Middle: R. — Last: Bidle

4. DATE OF DEATH: Month: 7 — Day: 2 — Year: 19 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 10/8/1876

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State, or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Daniel Bidle

14. MOTHER'S MAIDEN NAME: Mary Cline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Harold Holter, Middletown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
493X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic C-V Disease Arteriosclerosis, Senile.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 15 June, 1963, to 2 July, 1967, that (I) (we) last saw the deceased alive on 29 June 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3 July 1967

22c. PHYSICIAN'S NAME (Type): Dr. William N. Fender

22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 7/5/67

23c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

23d. LOCATION (City or Town) (County) (State): Middletown, Md.

24. FUNERAL DIRECTOR: Gladhill Company, Middletown — ADDRESS

25a. RECD BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10147 Item #7 Film #G321 8/16/67 pn

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11580

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 34 W. Franklin St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 34 W. Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ruth — Middle: — Last: Bishop
4. DATE OF DEATH: Month: July — Day: 31, — Year: 19 67
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ unknown WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 7, 1905
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Wash. Co. Welfare Board, Hag., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia Secondary — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): to Long Standing + Profound — 6-12 Mos
DUE TO (c): Malnutrition
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2265
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH:
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward W Ditto M.D.
EXAMINER'S NAME (Type): Edward W. Ditto, III, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 217 W. Washington St. Hagerstown, Maryland
22. DATE SIGNED: 8/8/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-10-67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md.
ADDRESS:
25a. REC'D BY REGISTRAR DATE: AUG 11 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATSME (S)-6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10145

1. PLACE OF DEATH — a COUNTY: Washington — MARYLAND
   b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c LENGTH OF STAY IN 1b:
   d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a STATE: Md. — b COUNTY: Wash.
   c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d STREET ADDRESS: 237 East Ave.
   e RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Calvin — Last: Bowers

4. DATE OF DEATH: Month: July — Day: 21, — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-30-1924

9. AGE (In years last birthday): 43 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): electrician

10b. KIND OF BUSINESS OR INDUSTRY: electrical contr.

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David R. Bowers

14. MOTHER'S MAIDEN NAME: Sarah J. Barton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO: 216-14-6173

17. INFORMANT: Mrs. Ramona Bowers, Hagerstown, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

H-201

IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic Heart Disease — Several Years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 7-22-67

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county): Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-24-67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md. — ADDRESS

25a. RECD BY REGISTRAR DATE: JUL 25 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10140

CERTIFICATE OF DEATH

146

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highfield
c. LENGTH OF STAY IN 1b: 31 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highfield
d. STREET ADDRESS:
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Upton Middle: Lee Last: Brown Sr.
4. DATE OF DEATH: Month: July Day: 22 Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/18/1911
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Landis Tool Co.
11. BIRTHPLACE (County & State, or foreign country): Lantz, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ivan Brown
14. MOTHER'S MAIDEN NAME: Alta Royer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service: No
16. SOCIAL SECURITY NO: 213-16-1936
17. INFORMANT: Mrs. Esther N. Brown, Highfield Md., Box 11 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Coronary Vascular Disease — 3 Months
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1967 to July 22, 1967 that (I) (we) last saw the deceased alive on July 21, 1967, and that death occurred at 3:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert A. Kiefer. M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 24 July 67
22c. PHYSICIAN'S NAME (Type): Robert A. Kiefer
22d. ADDRESS: Blue Ridge Summit, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/25/67
23c. NAME OF CEMETERY OR CREMATORY: St. Andrew
23d. LOCATION (City or Town) (County) (State): Waynesboro, Franklin Pa.

24. FUNERAL DIRECTOR: Walter Y. Stover, — ADDRESS: Waynesboro Pa.
25a. RECD BY REGISTRAR DATE: JUL 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10150

10147

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wash. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN This Place: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Smithsburg
d. STREET ADDRESS: Rural #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Brunner

4. DATE OF DEATH: Month: July — Day: 24 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: April 25 1879

9. AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pleasant Valley Wash.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thomas S Brunner

14. MOTHER'S MAIDEN NAME: Nancy Swope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-42-3964

17. INFORMANT — Address: Mrs. Pearline Lewis Smithsburg RFD#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriolar Nephrosclerosis — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Hypertensive arteriolar

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-13, 1967 to July 24, 1967, that (I) (we) last saw the deceased alive on 7-13 1967, and that death occurred at 10:00 A.M. from causes and on the date stated above.

22a. SIGNATURE: E. M. Landigrebe — M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 7-25-67

22c. PHYSICIAN'S NAME (Type): E. M. Landigrebe

22d. ADDRESS: 302 E. Antrim Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 26 1967

23c. NAME OF CEMETERY OR CREMATORY: Pleasant Valley

23d. LOCATION (City or Town) (County) (State): Smithsburg Wash Md

24. FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home Smithsburg Md.

25a. RECD BY REGISTRAR DATE: JUL 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10148

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c LENGTH OF STAY IN 1b: 27 yrs.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 223 S. Locust St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Keller — Middle: Earl — Last: Buhrman

4 DATE OF DEATH: Month: July — Day: 29 — Year: 19 67

5 SEX: Male — 6 COLOR OR RACE: White — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Nov. 2, 1901

9 AGE (In years last birthday): 65 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Inspector

10b KIND OF BUSINESS OR INDUSTRY: Railroad

11 BIRTHPLACE (State or foreign country): Foxville, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Henry G. Buhrman

14 MOTHER'S MAIDEN NAME: Mary Reynolds

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 214-14-6683

17 INFORMANT: Mrs. Edith Buhrman — Address: 223 S. Locust St. Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Aspiration of vomitus — INTERVAL BETWEEN ONSET AND DEATH: 3-4 hours
DUE TO
(b): multiple facial fracturs
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Auto accident

20c TIME OF INJURY Hour: 3:30 ☒ pm ☐ — Month, Day, Year: 7/29 19 67

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f (City or town) (County) (State): Hagerstown Wash. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.

EXAMINER'S NAME (Type): Howard N. Weeks, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 8/4/67

Address (Street, city, town, or county): 580 Northern Ave. Hagerstown, Maryla

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 8/1/67

23c NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

23d LOCATION (City or Town) (County) (State): Smithsburg - Washington - Md.

24 FUNERAL DIRECTOR: Wm. E. Hart — ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.

25a RECEIVED BY REGISTRAR DATE: AUG 7 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10152

10148

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
c. LENGTH OF STAY IN THIS PLACE: 3 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CLEARVIEW NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 38 NORTH AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PELLA — Middle STRATOS — Last CALLAS
4. DATE OF DEATH: Month JULY — Day 31, — Year 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: DEC. 24, 1900
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State or foreign country): BEZANI, GREECE
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: GREGORY STRATOS
14. MOTHER'S MAIDEN NAME: PANSJIOTA GRIVACOS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): ****
16. SOCIAL SECURITY NO: NONE
17. INFORMANT (Address): 1610 FOUNTAINHEAD RD.
MR. MICHAEL G. CALLAS, HAGERSTOWN, MARYLAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Vasc. Disease. — 17 yrs
DUE TO
(c): Arteriosclerosis - Generalized.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~XXX HOSPITAL~~ attended the deceased from July 22, 1952 to July 31, 1967, that (I) (~~XXX~~) last saw the deceased alive on July 31 1967, and that death occurred at 12:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: AUGUST 1, 1967
22c. PHYSICIAN'S NAME (Type): LLOYD A. HOFFMAN, M.D.
22d. ADDRESS: 214 N. POTOMAC ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/3/67
23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY
23d. LOCATION (City or Town) (County) (State): HAGERSTOWN, WASH. CO. MD.

24. FUNERAL DIRECTOR: CHARLES M. ROUZER, ADDRESS: HAGERSTOWN, MARYLAND.
25a. REC'D BY REGISTRAR: DATE AUG 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Yonge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10153

CERTIFICATE OF DEATH

1015

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c LENGTH OF STAY IN 1b: 26 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Moller Apts

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: Moller Apts
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: ANNA — Middle: ETHEL — Last: CHATKIN

4 DATE OF DEATH: Month: July — Day: 1 — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct 1 1893
9 AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b KIND OF BUSINESS OR INDUSTRY: Chatkins Phar.
11 BIRTHPLACE (County & State or foreign country): Pittsburg Penna
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Charles Chatkin
14 MOTHER'S MAIDEN NAME: Stella Pear

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----
16 SOCIAL SECURITY NO.:
17 INFORMANT: Robert H. Chatkin — Address: Moller Apts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
(b): Arteriosclerosis, Generalized — 4 Years
DUE TO
(c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1967, to July, 1967, that (I) (~~we~~) last saw the deceased alive on 30 June 1967 and that death occurred at 0200 M. from causes and on the date stated above

22a SIGNATURE: J. D. Wilson — M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 7/2/67
22c PHYSICIAN'S NAME (Type): J. D. Wilson
22d. ADDRESS:

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/3/67
23c NAME OF CEMETERY OR CREMATORY: B'Nai Abraham Cem.
23d LOCATION (City or Town) (County) (State): Half Way Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md.
25a. RECD BY REGISTRAR DATE: JUL 6 1967
25b REGISTRAR'S SIGNATURE: Charles Junge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10154

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10151

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 5 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3 WOODBINE LANE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
   d. STREET ADDRESS: 3 WOODBINE LANE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle EDGAR — Last COMBS

4. DATE OF DEATH: Month JULY — Day 27, — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 12, 1907

9. AGE (In years last birthday): 60 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER

10b. KIND OF BUSINESS OR INDUSTRY: MONUMENT WORKS

11. BIRTHPLACE (State or foreign country): MANCHESTER, KENTUCKY .

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. COMBS

14. MOTHER'S MAIDEN NAME: MARGARET LYTTLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service): W.W. II

16. SOCIAL SECURITY NO: 216-07-1727

17. INFORMANT: MRS. GLADYS B. COMBS — Address: 3 WOODBINE LANE, HAGERSTOWN, MARYLAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: week
DUE TO (b): athrosclerotic cardiovascular disease — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 7221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.

EXAMINER'S NAME (Type): HOWARD N. WEEKS, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 530 NORTHERN AVE. HAGERSTOWN, MARYLAND.

22. DATE SIGNED: 7/29/67

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 8/1/67

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY

23d. LOCATION (City or town, (County) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR — ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.

25a. RECD BY REGISTRAR — DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1 & 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMI. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10155

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10152

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- Weverton
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland — b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL- Weverton
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Robert — Middle: Trenton — Last: Comer

4 DATE OF DEATH: Month: 7 — Day: 14 — Year: 1967

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 5/12/30

9 AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman B&O Railroad

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Emory F. Comer

14 MOTHER'S MAIDEN NAME: Rachel H. Goode

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 218-24-9327

17 INFORMANT: Address: Mrs. Mary Catherine Comer, RFD2 Knoxvill

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: SEVERAL DAYS RECENT

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.
EXAMINER'S NAME (Type): DR. E.W.DITTO, JR.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: 7-14-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/17/67
23c NAME OF CEMETERY OR CREMATORY: Edge Hill Cemetery
23d LOCATION (City or Town, (County) (State): Charlestown W. Va.

24 FUNERAL DIRECTOR: Feete Funeral Home
ADDRESS: Brunswick Md.

25a REC'D BY REGISTRAR DATE: JUL 18 1967
25b REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10156 (10153)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): rural Hagerstown
c. LENGTH OF STAY IN 1b: 28 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RFD 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): rural Hagerstown
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Walter	Hoge	Conrad	July	5,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white		10-7-94	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	farm	Jiles Co., Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edmund Conrad	Nancy Croy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	220-18-0108	Mrs. Emma Conrad, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	Instant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Cardio Vascular Disease	Several years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1, 1967, to July 5, 1967, that (I) (we) last saw the deceased alive on June 30, 1967, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E. W. Ditto Jr. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7-7-67

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr. — 22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	7-8-67	Cedar Lawn Mem. Park	Hagerstown, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Minnich Funeral Home, Hagerstown, Md.	JUL 10 1967	Charles Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10157 10151

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN this place: 35 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown,
d. STREET ADDRESS: 636 Guilford Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: McClelland — Last: Cunninghan

4. DATE OF DEATH: Month: July — Day: 6 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 22, 1885

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor

10b. KIND OF BUSINESS OR INDUSTRY: Penna R.R.

11. BIRTHPLACE (County & State, or foreign country): Greencastle Franklin Co Pa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Cunningham

14. MOTHER'S MAIDEN NAME: Elizabeth Lane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 701-09-9361

17. INFORMANT Address: Mrs Hazel Cunningham 636 Guilford Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 12 Hours
DUE TO (b): Atherosclerotic heart disease — unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7401

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastro-intestinal hemorrhage, repeated; Azotemia, multiple pulmonary embolism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~[illegible]~~ attended the deceased from June 19, 1967 to July 6, 1967, that (I) ~~[illegible]~~ last saw the deceased alive on July 6, 1967, and that death occurred at 11:04 p.m., from causes and on the date stated above.

22a. SIGNATURE: W. T. Layman M.D.
M.D ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: July 8, 1967

22c. PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22d. ADDRESS: 100 Professional Arts Bldg, Hag., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/10/67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR ADDRESS: Andrew K. Coffman Funeral Home Inc Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUL 10 1967

25b. REGISTRAR'S SIGNATURE: Elmer Snyder

I

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only deputy is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10158

155

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN (RURAL)
c LENGTH OF STAY IN 1b: 6 YEARS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: MARYLAND — b COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HALFWAY
d STREET ADDRESS: 2011 VIRGINIA AVENUE
e IS RESIDENCE ON A FARM? YES ☐ NO XX

3 NAME OF DECEASED (Type or print): First MARTIN — Middle LEROY — Last CUPERNALL

4 DATE OF DEATH: Month JULY — Day 24 — Year 1967

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: SEPT. 7, 1947

9 AGE (In years last birthday): 19 yrs — IF UNDER 1 Yr: Months, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): TREE SURGEON

10b KIND OF BUSINESS OR INDUSTRY: ****

11 BIRTHPLACE (State or foreign country): AUGENSBURG, NEW YORK

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: LEROY HIRAM CUPERNALL

14 MOTHER'S MAIDEN NAME: KATHERINE LOVELAND

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): NO ***

16 SOCIAL SECURITY NO: 220-42-5831

17 INFORMANT (Address): MR. LEROY H. CUPERNALL, 2011 VIRGINIA AVE. HALFWAY, MARYLAND.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Fractured skull — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
823.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Auto collision-car hit utility pole

20c TIME OF INJURY Month, Day, Year Hour: 12:30xx 7/24 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.): Street

20f (City or town) (County) (State): Hagerstown, Wash., Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N Weeks M.D.

EXAMINER'S NAME (Type): HOWARD N. WEEKS, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22 DATE SIGNED: 7/25/67

Address (Street city town or county): 580 NORTHERN AVE. HAGERSTOWN, MD.

23a BURIAL CREMATION REMOVAL (Specify): BURIAL

23b DATE THEREOF: 7/27/67

23c NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d LOCATION (City or town) (County) (State): HAGERSTOWN, WASH. CO. MD.

24 FUNERAL DIRECTOR ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.

25a RECD BY REGISTRAR DATE: JUL 31 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10159

CERTIFICATE OF DEATH

10156

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 42 DAYS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SMITHSBURG
d. STREET ADDRESS: 185 NAVAHO CIRCLE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MARY — Middle: PEARL — Last: DANNER
4 DATE OF DEATH: Month: JULY — Day: 24, — Year: 19 67

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 1, 1886 (1891)
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): PIEDMONT, WEST VIRGINIA
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: SANFORD MONTGOMERY
14. MOTHER'S MAIDEN NAME: SUSAN (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): *****
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: MRS. MARY E. MORGANTHALL, SMITHSBURG, MD. — Address: ROUTE #2 BOX 185

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatorenal Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Metastatic CA. Endometrium — 18 mo.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/3, 19 67 to 7/24, 19 67, that (I) (we) last saw the deceased alive on 7/24 19 67 and that death occurred at 5:10 P.M. from causes and on the date stated above.

22a. SIGNATURE: D. J. Boyer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: JULY 25, 1967
22c. PHYSICIAN'S NAME (Type): DAVID J. BOYER, M.D.
22d. ADDRESS: 136 N. POTOMAC ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7/27/67
23c NAME OF CEMETERY OR CREMATORY: MARVIN HILL CHAPEL
23d LOCATION (City or Town) (County) (State): MT. AIRY, HOWARD CO. MD.

24. FUNERAL DIRECTOR — ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.
25a RECD BY REGISTRAR DATE: JUL 31 1967
25b REGISTRAR'S SIGNATURE: [illegible] judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10160

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: E. Northern Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary Middle Elva Last Leslie Davis
4. DATE OF DEATH: Month July Day 12, Year 1967
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-10-1891
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Blairs Valley, Pa.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John S. Wilson
14. MOTHER'S MAIDEN NAME: Joann Robinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-14-1785T
17. INFORMANT: George Davis Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs.
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis, Gen. — not known
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Umbilical Hernia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/7, 1967, to 7/12, 1967, that (I) (we) last saw the deceased alive on 7/12 1967, and that death occurred at 6:00 M, from the causes and on the date stated above.

22a. SIGNATURE: Harold Lupo M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/12/67
22c. PHYSICIAN'S NAME (Type): HARUKO RIGO
22d. ADDRESS: 159 W. Washington St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-14-67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town or county) (State): Hagerstonw, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: JUL 17 1967
25b. REGISTRAR'S SIGNATURE: Charles Snyder

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10161

CERTIFICATE OF DEATH

10153

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 50 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 2613 VIRGINIA AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle EDWARD — Last DAWSON

4. DATE OF DEATH: Month JULY — Day 17, — Year 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
MALE	WHITE		MAY 26, 1893	74 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED P.E. EMPLOYEE	POTOMAC EDISON CO.	PAGE CO. VIRGINIA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH DAWSON	SARSH WEAVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
NO	****	214-10-5537-A	TRUST DEPT. FIRST NATIONAL BANK OF MARYLAND.	HAGERSTOWN, MARYLAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	hemorrhagic diathesis	weeks
DUE TO (b)	fibrinolysis	weeks
DUE TO (c)	carcinoma of bowel	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1539

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (~~WE~~) attended the deceased from _____, 19____, to death, 19____, that (I) (~~WE~~) last saw the deceased alive on 16 July 19 67, and that death occurred at _____M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
John C. Stauffer		

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
JOHN C. STAUFFER, M.D.	145 S. PROSPECT ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	7/19/67	ROSE HILL CEMETERY,	HAGERSTOWN, WASH.CO. MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.	JUL 20 1967	Charles Rouzer

1

10162

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Item #2d Film #6371 7/27/67 ph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Friendship Manor Nursing Home Hagerstown Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Williamsport, Rt. 1 Friendship Manor Nursing Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Newlah — Middle: Crace — Last: Delauter
4. DATE OF DEATH: Month: July — Day: 20 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 28 1896
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.: 3 / 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John E. Delauter
14. MOTHER'S MAIDEN NAME: Catherine Palmer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 219 542 335
17. INFORMANT: Mrs. Bessie Head — Address: 131 E. Baltimore St. Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b): — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec, 1965 to 7-20, 1967, that (I) (we) last saw the deceased alive on 7-20- 1967, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert P. Conrad M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7-21-67
22c. PHYSICIAN'S NAME (Type): Robert P. Conrad — 22d. ADDRESS: Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: July 23-67 — 23c. NAME OF CEMETERY OR CREMATORY: Manor Cemetery — 23d. LOCATION (City, town or county) (State): Near Tilghmanton Md.

24. FUNERAL DIRECTOR — ADDRESS: Albert I. Leaf — Williamsport Maryland
25a. REC'D BY REGISTRAR DATE: JUL 24 1967 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4) 20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10163

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BIG POOL
c. LENGTH OF STAY IN 1b: 18 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOME, BIG POOL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BIG POOL
d. STREET ADDRESS: BIG POOL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First CHESTER Middle WILLIAM Last DeSHONG

4 DATE OF DEATH: Month JULY Day 12, Year 1967

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8 DATE OF BIRTH: 7/29/1905

9 AGE (In years last birthday): 61 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done dur ng most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: LUMBER

11. BIRTHPLACE (County & State, or foreign country): FULTON Co, PENNA.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: SAMUEL LOGUE DeSHONG

14. MOTHER'S MAIDEN NAME: ELSIE IRENE DECKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 204-018702

17. INFORMANT: ROBERT C. DeSHONG, Address: BIG POOL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: instant
DUE TO (b): Arteriosclerosis
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work [ ] Not While at work [ ]

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1966, to July 12, 1967 that (I) (we) last saw the deceased alive on May 2 1967, and that death occurred at 6:07 M, from causes and on the date stated above.

22a SIGNATURE: L.M. Shaffer M.D. ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22b DATE SIGNED: 7/14/67

22c PHYSICIAN'S NAME (Type): L.M. SHAFFER

22d ADDRESS: Hancock, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 7/15/67

23c. NAME OF CEMETERY OR CREMATORY: SIDLING HILL CHRISTIAN HARRISONVILLE

23d LOCATION (City or Town) (County) (State): PENNA.

24. FUNERAL DIRECTOR: Richard J. Grove ADDRESS: Hancock, Md.

25a REGISTRAR RECEIVED: JUL 17 1967 25b REGISTRAR'S SIGNATURE: Charles Judge

DATE: JUL 17 1967

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10164

CERTIFICATE OF DEATH

3161

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
d STREET ADDRESS: 117 Potomac St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Easterday

4 DATE OF DEATH: Month: July — Day: 3, — Year: 19 67

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: May 5, 1885
9 AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: 1 — Days: 28
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b KIND OF BUSINESS OR INDUSTRY: Water Co.
11 BIRTHPLACE (County & State or foreign country): Boonsboro, Md.
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frisby Easterday
14. MOTHER'S MAIDEN NAME: Martha Ann Easterday

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO: 220-05-6899
17 INFORMANT: Mr. Edmund R. Easterday, 623 N. Locust St. — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intermittent Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May 5, 1962, to July 3, 1967, that (I) (we) last saw the deceased alive on June 28 1967, and that death occurred at 7:00 AM, from causes and on the date stated above

22a SIGNATURE: Dan'l. W. LeVan /m.d.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: July 4, 1967
22c. PHYSICIAN'S NAME (Type): Dan'l W. LeVan /m.d.
22d ADDRESS: Boonsboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7- 6- 67
23c NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery
23d LOCATION (City or Town) (County) (State): Boonsboro, Md.

24. FUNERAL DIRECTOR ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.
25a RECEIVED BY REG STRAR DATE: JUL 7 1967
25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10165

CERTIFICATE OF DEATH

3182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Yrs
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 228 No Potomac St

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 228 No Potomac St
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARY — Middle LELLY — Last ENGROFF
4 DATE OF DEATH: Month July — Day 4 — Year 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: May 18 1892
9 AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (County & State or foreign country): Juniata Co Penna
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John A. Leech
14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ------
16. SOCIAL SECURITY NO: 220-52-2110
17 INFORMANT: Mary C. Braham — Address: 228 No potomac St

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Hypertension Heart Disease — 3 yrs
DUE TO (c):
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/25, 19 65, to 7/4, 19 67, that (I) (we) last saw the deceased alive on 6/13 19 67, and that death occurred at 4:45 P.M., from causes and on the date stated above.

22a SIGNATURE: Donald E Martin M.D — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7/5/67
22c PHYSICIAN'S NAME (Type): Donald E. Martin, M.D.
22d ADDRESS: 418 N. Potomac St., Hagerstown, Md. 21740

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/7/67
23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24 FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md
25a REC'D BY REGISTRAR DATE: JUL 10 1967
25b REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10166

CERTIFICATE OF DEATH

10193

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Boonsboro
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rfd. 2 Mapleville

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Boonsboro, Rfd. 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Nancy — Middle: Evelyn — Last: Faulder

4 DATE OF DEATH: Month: July — Day: 13, — Year: 19 67

5 SEX: Female

6. COLOR OR RACE: White

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 10, 1889

9 AGE (In years ost birthday): 78 yrs

IF UNDER 1 YEAR: Months: 4 — Days: 3
IF UNDER 24 HRS: Hours: — Min:

10a USUAL OCCUPATION (Give k nd of work done during most of working life, even f retired): Housewife

10b K ND OF BUSINESS OR INDUSTRY: Own Home

11 BIRTHPLACE (County & State or foreign country): Washington Co., Md.

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: David E. Stine

14. MOTHER'S MAIDEN NAME: Clara Baker

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.

16 SOCIAL SECURITY NO: None

17 INFORMANT Address: Mrs. Daisy Faulder, Boonsboro Rfd. 2, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years
I60X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Diabetes
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLY NG ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF IN.URY Month, Day, Year, Hour o.m. p.m. 19

20d IN.URY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF IN.URY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 19 65 to July 13, 19 67, that (I) (we) last saw the deceased alive on July 12, 1967, and that death occurred at 6:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: A. W. Ditto — M.D — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: 7-15-67

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d ADDRESS: Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7- 16- 67

23c NAME OF CEMETERY OR CREMATORY: Mt. Lena Cemetery

23d .OCATION (City or Town) (County) (State): Mt. Lena, Md.

24 FUNERAL DIRECTOR ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.

25a REC'D BY REGISTRAR DATE: JUL 18 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10167

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Washington Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md
c. LENGTH OF STAY IN 1b: [redacted] 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: 109 Jackson Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Brenda — Middle: Sue — Last: Fearnow

4 DATE OF DEATH: Month: 7 — Day: 31 — Year: 19 67

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8 DATE OF BIRTH: 8/21/57

9. AGE (In years last birthday): 7 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Washington Co, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13 FATHER'S NAME: Clyde Lee Fearnow

14 MOTHER'S MAIDEN NAME: Doris Jean Truax

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: —

17 INFORMANT — Address: Clyde Fearnow — Williamsport, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Uremia — 6 mos.
DUE TO (c): Fanconi Syndrome — 7½ yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/21, 1957, to 7/31, 1967, that (I) (we) last saw the deceased alive on 7/31 1967, and that death occurred at 1:50 P M, from causes and on the date stated above.

22a. SIGNATURE: Richard A. Young M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/31/67

22c. PHYSICIAN'S NAME (Type): Richard A. Young

22d. ADDRESS: 101 King Street, Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-3-67

23c. NAME OF CEMETERY OR CREMATORY: Union Chapel Cemetery

23d. LOCATION (City or Town) (County) (State): Berkley Springs, W.Va.

24. FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home, Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: AUG 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

1

FOR STATE HEALTH DEPT.

TO DEFER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10168 — 10165

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 2
d. STREET ADDRESS: Connocheague Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle WILLIAM — Last FLETCHER

4. DATE OF DEATH: Month July — Day 29 — Year 1967

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jany 4 1908 — 9. AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months ___ Days ___ — IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Roofing Co.
11. BIRTHPLACE (State or foreign country): Bedford County Pa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Fletcher
14. MOTHER'S MAIDEN NAME: Clara Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N
(If yes give war or dates of service): ------
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: Mrs Edna M. Long Hagerstown Md. R# 4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Basal skull fracture — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Victim fell down steps at his home
20c. TIME OF INJURY Month, Day, Year — Hour: 1:00 pm — 7/29 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or Town) (County) (State): Hagerstown, Wash., Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D
EXAMINER'S NAME (Type): Howard N. Weeks, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 7/31/67
Address (Street, city, town, or county): 580 Northern Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/1/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md.
25a. REC'D BY REGISTRAR — DATE: AUG 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1'67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10169

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10169

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN ID: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: UTAH — b. COUNTY: TOOELE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALT LAKE CITY
d. STREET ADDRESS: 1990 S. 21 ST. EAST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RICHARD — Middle: VERGIL — Last: FOWLER
4. DATE OF DEATH: Month: 7-1 — Day — Year: 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 29, 1944
9. AGE (In years last birthday): 22 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEERING TECHN.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVERNMENT
11. BIRTHPLACE (State or foreign country): TAKOMA, WASHINGTON
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: RICHARD H. FOWLER
14. MOTHER'S MAIDEN NAME: FLORINNE ANKUDOWICZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO: 539-40-9008
17. INFORMANT: MRS. SHARON T. FOWLER, Address: 1990 S. 21 ST. EAST. SALT LAKE CITY, UTAH.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): FRACTURED SKULL WITH INTRACEREBRAL HEMORRHAGE AND SUB DURAL HEMATOMA
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 40 HRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): SEVERELY BEATEN BY UNKNOWN PERSONS
20c. TIME OF INJURY: Hour 2:30 pm — Month: 6-30 — Year: 19 67
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): PUBLIC HIGHWAY
20f. (City or town) CHAMBERSBURG, (County) (State) PA.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): DR. E.W.DITTO,JR.
Address (Street, city, town, or county):
22. DATE SIGNED: 7-2-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/5/67
23c. NAME OF CEMETERY OR CREMATORY: TOOELE CITY CEMETERY,
23d. LOCATION (City or Town) (County) (State): TOOELE CITY, TOOELE, UTAH.

24. FUNERAL DIRECTOR — ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.
25. REC'D BY REGISTRAR — DATE: JUL 5 1967
25b. REGISTRAR'S SIGNATURE: [signature]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10170

CERTIFICATE OF DEATH

10167

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 42 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 43 SOUTH PROSPECT STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First NORMAN — Middle EDGAR — Last GEISELMAN

4. DATE OF DEATH: Month JULY — Day 9, — Year 19 67

5 SEX	6 COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
MALE	WHITE	WIDOWED ☒	JUNE 29, 1899	68 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED SALES MGR.	MANUFACTURING FIRM	HANOVER, PENNSYLVANIA	U.S.A.

13. FATHER'S NAME: DANIEL GEISELMAN

14 MOTHER'S MAIDEN NAME: AMELIA STAMBAUGH

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT (Address)
NO	****	214-09-0023 A	MRS. LUCILLE RONEY, ROUTE 1, CLEAR SPRING, MARYLAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART	DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH
I	IMMEDIATE CAUSE (a)	Acute myocardial infarction	2-3 days
	DUE TO (b)	Coronary arteriosclerosis -	years.
	DUE TO (c)	Arteriosclerotic Cardiov. Dis.	years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic hypertrophic Lumbarsacral Osteoarthritis, Diabetes mellitus

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from March, 19 67 to July, 19 67, that (I) (we) last saw the deceased alive on 4 July 1967, and that death occurred at 6 P.M., from causes and on the date stated above.

22a. SIGNATURE: Richard T. Binford — M.D. — ATTENDING PHYS. ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: JULY 12, 1967

22c. PHYSICIAN'S NAME (Type): RICHARD T. BINFORD, M.D.

22d. ADDRESS: 1135 POTOMAC AVE. HAGERSTOWN, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	7/12/67	ROSE HILL CEMETERY	HAGERSTOWN, WASH. CO. MD.

24. FUNERAL DIRECTOR — ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.

25a RECD BY REGISTRAR — DATE: JUL 14 1967

25b REGISTRAR'S SIGNATURE: Julia Mae Yingling

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10171

CERTIFICATE OF DEATH

10168

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cascade, Md. R.D.1
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cascade (Rural) 21-1
d. STREET ADDRESS: R.D.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Guernon — Middle: C. — Last: Harbaugh
4. DATE OF DEATH: Month: July — Day: 16 — Year: 19 67
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/30/1904
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): red rick Co. Md. Harbaugh's Valley
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Arben Harbaugh
14. MOTHER'S MAIDEN NAME: Fannie Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 173-03-2686
17. INFORMANT: Mrs. Richard E. "arbaugh — Address: Cascade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 18-15 dys
DUE TO (b): Coronary Insufficiency — 1-2 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2 March 1957 to 16 July 1967, that (I) (we) last saw the deceased alive on 15 July 1967, and that death occurred at 10:4 M. from causes and on the date stated above.

22a. SIGNATURE: Harry Youngs Jr. — M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7-18-67.
22c. PHYSICIAN'S NAME (Type): Harry H. Youngs Jr.
22d. ADDRESS: Blue Ridge Summit, Penna.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/19/1967
23c. NAME OF CEMETERY OR CREMATORY: Bethel
23d. LOCATION (City or Town) (County) (State): Washington County, Md.

24. FUNERAL DIRECTOR: Walter Y. Gore — ADDRESS: Waynesboro, Pa.
25a. REC'D BY REGISTRAR DATE: JUL 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jorgo

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10172

CERTIFICATE OF DEATH

10169

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c LENGTH OF STAY IN 1b: 6 Years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jackson Conv. Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Penna — b. COUNTY: Franklin
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d STREET ADDRESS: 422 West Sixth St
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MINNIE Middle MAE Last HARP
4 DATE OF DEATH: Month July Day 29 Year 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Jany 9 1874
9 AGE (In years last birthday): 93 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (County & State or foreign country): Mt Lena Wash Co Md.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Luther Lumm
14 MOTHER'S MAIDEN NAME: Mary McKinsey

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ------
16 SOCIAL SECURITY NO: None
17 INFORMANT: Reno O. Harp — Address: 906 Mulberry Ave

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): PNEUMONITIS — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ___
DUE TO
(c) ___

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): RHEUMATIC HEART DISEASE
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 27, 1967, to July 29 1967, that (I) (~~we~~) last saw the deceased alive on July 28 1967, and that death occurred at 4:45 PM, from causes and on the date stated above.

22a SIGNATURE: W. J. Layman, M.D. — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: Aug 1, 1967
22c. PHYSICIAN'S NAME (Type): W. J. LAYMAN, M.D.
22d. ADDRESS: 5 Public Square Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8/1/67
23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24 FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md.
25a RECD BY REGISTRAR DATE: AUG 2 1967
25b REGISTRAR'S SIGNATURE: Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page(s) 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10173

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 49 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1041 GEORGIA AVENUE,

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1041 GEORGIA AVENUE,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: EDGAR — Middle: CHARLES — Last: HELMAN

4. DATE OF DEATH: Month: JULY — Day: 7, — Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED ☒	FEBRUARY 24,1902	65 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
RETIRED MAINTAINANCE &	W.MD. RAILROAD	FRANKLIN CO. PENNSYLVANIA,	U.S.A.

13. FATHER'S NAME: WAYS DEPT. IVAN HELMAN
14 MOTHER'S MAIDEN NAME: CHARLOTTE HELMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	Address
NO	***	705-10-5786	MRS. VIRGINIA H. HELMAN,	1041 GEORGIA AVE. HAGERSTOWN, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
4201
DUE TO
(b): Atherosclerotic heart disease — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21 I certify that (I) (~~the hospital~~) attended the deceased from July 7, 19 67 to July 7, 1967, that (I) (~~we~~) last saw the deceased alive on ____ 19____, and that death occurred at 3:15 A.M. from causes and on the date stated above.

22a SIGNATURE: W. T. Layman, M.D. — M.D. — ATTENDING PHYS. ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: JULY 8, 1967
22c. PHYSICIAN'S NAME (Type): WILLIAM T. LAYMAN, M.D.
22d. ADDRESS: PROFESSIONAL ARTS BLDG. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	7/10/67	REST HAVEN CEMETERY,	HAGERSTOWN, WASH.CO. MD.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.	JUL 14 1967	J. Charles Yingling

1

10174

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown; c. LENGTH OF STAY IN 1b: 43 years; d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md.; b. COUNTY: Wash.; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown; d. STREET ADDRESS: 1260 Ravenswood Hgths; e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Floyd; Middle: House; Last: Hightman

4. DATE OF DEATH: Month: July; Day: 15,; Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-25-1900

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): letter carrier

10b. KIND OF BUSINESS OR INDUSTRY: post office

11. BIRTHPLACE (County & State, or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Cecil Hightman

14. MOTHER'S MAIDEN NAME: Mary House

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-42-5934

17. INFORMANT — Address: Mrs. Pauline Hightman, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — Yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebro Vascular Thrombosis - Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [1963], to 15 July 1967, that (I) (we) last saw the deceased alive on 15 July 1967, and that death occurred at 6:07 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. O. Fender — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 17 July 67

22c. PHYSICIAN'S NAME (Type): W.N. Fender

22d. ADDRESS: 218 N. Potomac St. Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-18-67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Park

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10175

CERTIFICATE OF DEATH

2172

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 9 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Homewood Church Home Inc

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 223 So Market St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BLANCHE Middle ESTELLE Last HILDEBRAND

4. DATE OF DEATH: Month July Day 10 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feby 12 1879
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Book keeper
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (County & State, or foreign country): Md Frederick Frederick Co
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis M. Hildebrand
14. MOTHER'S MAIDEN NAME: Laura V. Staley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: A 214-10-1811
17. INFORMANT: Rev Mark G. Wagner Address: 2750 Virginia Ave Williamsport Md. 21795

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hypertensive C. V. Dis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO (b): ____
DUE TO (c): ____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-15, 1965, to 7-10, 1967, that (I) (we) last saw the deceased alive on 7-6-1967, and that death occurred at 4 A.M., from causes and on the date stated above

22a. SIGNATURE: Robert P. Conrad M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7-10-67
22c. PHYSICIAN'S NAME (Type): Robert P. Conrad
22d. ADDRESS: Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 19-1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Frederick, Md. 21701

24. FUNERAL DIRECTOR: Elwood T. Whitmore M.R.Etchison & Son
ADDRESS: Frederick, Md.21701
25a. REC'D BY REGISTRAR DATE: JUL 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10176

CERTIFICATE OF DEATH

10173

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 1 Yr-2mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Homewood Church Home, Inc.

2 USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 5709 Woodcrest
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARY — Middle NMN — Last HOFFMAN
4 DATE OF DEATH: Month July — Day 21 — Year 1967
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Mar. 14, 1876
9 AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b KIND OF BUSINESS OR INDUSTRY: Housekeeper
11 BIRTHPLACE (County & State, or foreign country): Penna Pittsburg, Alleghany Cty
12 CITIZEN OF WHAT COUNTRY? U.S.A

13 FATHER'S NAME: John Hoffman
14 MOTHER'S MAIDEN NAME: Helena Hogge

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): --
16 SOCIAL SECURITY NO: 312-32-2294A
17 INFORMANT: Rev. Mark Wagner, Address: 2750 Virginia Ave Williamsport, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b): Hypertensive C. V. Dis — 15yrs.
DUE TO
(c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-15, 1965, to 7-21, 1967, that (I) (we) last saw the deceased alive on 7-21 1967, and that death occurred at 10:?? M, from causes and on the date stated above.

22a. SIGNATURE: Robert P. Conrad M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7-22-67
22c. PHYSICIAN'S NAME (Type): Robert P. Conrad
22d. ADDRESS: Hagerstown, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: July 24, 1967
23c NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d LOCATION (City or Town) (County) (State): Baltimore, Md.

24 FUNERAL DIRECTOR ADDRESS: A. K. Coffman Funeral Home, Inc. Hagerstown, Md.
25a RECD BY REGISTRAR DATE: JUL 28 1967
25b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10177

CERTIFICATE OF DEATH

10174

1. PLACE OF DEATH
a. COUNTY WASHINGTON
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MARYLAND b COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
d. STREET ADDRESS 15 BRIGHTWOOD CIRCLE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle BLANCHE Last HORN
4. DATE OF DEATH Month JULY Day 25 Year 1967
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 2/10/1886
9. AGE (In years last birthday) 81 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY HOME
11 BIRTHPLACE (County & State, or foreign country) MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM A. HOSE
14. MOTHER'S MAIDEN NAME MARY E. BAUGHMAN
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16 SOCIAL SECURITY NO NONE
17 INFORMANT MRS. PATRICIA MYERS Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 30 min.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular disease, arteriosclerotic — Indefinite
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19 45 to July 25, 1967, that (I) (we) last saw the deceased alive on July 25 1967, and that death occurred at 10:35 A.M. from causes and on the date stated above.

22a. SIGNATURE B. B. Kneisley M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 7/26/67
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.
22d. ADDRESS 148 West Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 7/27/67
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.
23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.

24 FUNERAL DIRECTOR W. J. Nonemit ADDRESS Hagerstown, Md.
25a REC'D BY REGISTRAR DATE JUL 31 1967
25b REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH/DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10175

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Ritchie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Army Dispensary

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Mass. b. COUNTY: Bristol
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Dighton
d. STREET ADDRESS: 707 Green Acres
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JANE Middle: CHAMBERLAIN Last: Horton

4. DATE OF DEATH: Month: 7 Day: 3 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr. 18, 1900

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Companion

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Stoneham, Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Arthur Webber

14. MOTHER'S MAIDEN NAME: Ada Chamberlain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Donna Lee Horton, Bldg 469, Ft. Ritchie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thromboses — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Coronary Artery — 7 yrs
DUE TO
(c): disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.

EXAMINER'S NAME (Type): Howard N. WEEKS

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 520 Northern Av Hagerstown Md.

DATE SIGNED: 7/4/67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/8/1967

22c. NAME OF CEMETERY OR CREMATORY: Colebrook Cemetery

22d. LOCATION (City, town, or county) (State): Rehoboth, Mass.

23. FUNERAL DIRECTOR: H. Marlin Roe ADDRESS: Waynesboro, Penna.

24a. REC'D BY REGISTRAR DATE: JUL 6 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A1SME (5)
6M 1/67

10179

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL HAGERSTOWN
c LENGTH OF STAY IN To: LIFE
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): RT#2 HAGERSTOWN (CHARLES MILL)

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a STATE: MARYLAND — b COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d STREET ADDRESS: 525 RIDGE AVE.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JAMES — Middle GRANTIAN — Last HOWELL

4 DATE OF DEATH: Month JULY — Day 28 — Year 1967

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8 DATE OF BIRTH: 8/6/1918

9 AGE (In years last birthday): 48 yrs

UNDER 1 YEAR: Months — Days
UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): WEAVER

10b KIND OF BUSINESS OR INDUSTRY: TEXTILE MFG. CO.

11 BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: LEE HAMILTON HOWELL

14. MOTHER'S MAIDEN NAME: NEVA GOENS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): YES — W.W.#2

16 SOCIAL SECURITY NO.: 220-09-7513

17 INFORMANT: MRS. HELEN B. HOWELL — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Dived into River To check Boat

20c TIME OF INJURY Hour, Day, Year: Hour XX — 7:00 pm — 7/28 1967

20d INJURY OCCURRED While at work ☐ — Not While at work ☒

20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.): Pate River

20f (City or town) (County) (State): Hagerstown Wash. Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.

EXAMINER'S NAME (Type): Howard N. Weeks, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 7/31/67

Address (Street city, town or county): 580 Northern Ave. Hagerstown, Md.

23a BURIAL REMOVAL CREMATION: BURIAL

23b DATE THEREOF: 7/31/67

23c NAME OF CEMETERY OR CREMATORY: CEDAR LAWN MEM. PARK

23d LOCATION (City or Town) (County) (State): HAGERSTOWN WASH. MD.

24 FUNERAL DIRECTOR: W. T. Norment — ADDRESS: Hagerstown Md.

25a RECD BY REGISTRAR DATE: AUG 1 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (1)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10180

CERTIFICATE OF DEATH

10177

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 425 Indiana Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: SUSIE Middle: HIVLEN Last: HULL

4. **DATE OF DEATH**: Month Day Year: July 25 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 30 1892

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Md. Clear Spring Wash Co

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Archibald McAllister

14. MOTHER'S MAIDEN NAME: Emma guffacool

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO: None

17. **INFORMANT** Address: Gilbert P. Hull 425 Indiana Ave

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pulmonary Embolus Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: Few minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arteriosclerotic Cardio Vascular Disease With — Recent
DUE TO
(c): Cardiac Decompensation.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 14, , 19 67, to July 25, , 1967, that (I) (we) last saw the deceased alive on July 24, 19 67, and that death occurred at 10:50 A.M., from causes and on the date stated above.

22a. SIGNATURE: E. W. Ditto Jr. M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-26-67

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/27/67

23c. NAME OF CEMETERY OR CREMATORY: St Pauls Cemetery near Clear Spring

23d. LOCATION (City or Town) (County) (State): Md. Wash Co

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc ADDRESS: Hagerstown Md

25a. REC'D BY REGISTRAR DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Junge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HANCOCK
c LENGTH OF STAY IN 1b: 1 DAY
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): INTERSTATE 70 I

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: NEW YORK — b COUNTY: JEFFERSON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ADAMS CENTER
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First LOYAL — Middle F. — Last HURLEY

4 DATE OF DEATH: Month JULY — Day 24, — Year 19 67

5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: AUG. 23, 1886
9 AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINISTER
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): GARWIN, IOWA.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: THEODORE S. HURLEY
14 MOTHER'S MAIDEN NAME: EVA MAY DAVIS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16 SOCIAL SECURITY NO: 105-28-8168
17 INFORMANT: MILDRED L BURT — Address: ADAMS CENTER N.Y.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Compound skull fracture — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19 WAS A TOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Auto-auto collision
20c TIME OF INJURY Month Day, Year Hour a.m.: 12 noon 7/24 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Highway
20f (City or town) (County) (State): Route 70 W. of Hancock, M

21 I certify that I took charge of the remains described above held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.
EXAMINER'S NAME (Type): HOWARD N. WEEKS, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 7/25/67
Address (Street, city, town or county): 580 NORTHERN AVE. HAGERSTOWN, MARYLAND.

23a BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b DATE THEREOF: 7/25/67
23c NAME OF CEMETERY OR CREMATORY: UNION CEMETERY,
23d LOCATION (City or Town) (County) (State): ADAMS CENTER, JEFF. CO. N.Y.

24 FUNERAL DIRECTOR: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.
ADDRESS:
25a RECD BY REGISTRAR DATE: JUL 31 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

YR A15ME (5) 6M 67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and within any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10182

CERTIFICATE OF DEATH

10179

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 16 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Memorial Convalescent Hospital

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Md.
b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg
d. STREET ADDRESS: 20 West Water St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elenora — Middle: -- — Last: Itnyer

4. DATE OF DEATH: Month: July — Day: 24 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 18, 1886

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Franklin Co., Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Shank

14. MOTHER'S MAIDEN NAME: Annie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 218-30-9740

17. INFORMANT: Ronald L. Itnyer — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardio myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): arterio - sclerotic heart disease — 30 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis - (arrested) -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 30 to 7-24, 19 67 that (I) (we) last saw the deceased alive on May-24 1967, and that death occurred at 1:15 PM, from causes and on the date stated above

22a. SIGNATURE: Walter H Wishard — MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-25-67

22c. PHYSICIAN'S NAME (Type): Walter H Wishard

22d. ADDRESS: 152 W main St Waynesboro Penna

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

23d. LOCATION (City or Town) (County) (State): Smithsburg Wash. Md.

24. FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home, Smithsburg, Md.

25a. RECD BY REGISTRAR DATE: JUL 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10183

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
2DM 5-63

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
c. LENGTH OF STAY IN 1b: Aug. 26-1961
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fahrney-Keedy Memorial Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4206 Loch Raven Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie; Middle: Jane; Last: Keen

4. DATE OF DEATH: Month: July; Day: 20; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 4-1875

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Alexander Kennedy

14. MOTHER'S MAIDEN NAME: Sarah Chester

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. John R. Fogle Same
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Vascular
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 5 Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. / Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 2, 19 67 to July 20, 19 67, that (I) (we) last saw the deceased alive on July 20, 19 67, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: F. W. LeVan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/20/67

22c. PHYSICIAN'S NAME (Type): F. W. LE VAN

22d. ADDRESS: BOONSBORO, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-22-67
23c. NAME OF CEMETERY OR CREMATORY: Oaklawn
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto.

25a. REC'D BY REGISTRAR DATE: JUL 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 of

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10184

CERTIFICATE OF DEATH

10181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a COUNTY: WASHINGTON
MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c LENGTH OF STAY IN 1b: 4 MOS.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MARYLAND
b COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d STREET ADDRESS: 1833 WOODBURN DRIVE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JENNIE Middle DREW Last KELLUM
4 DATE OF DEATH: Month JULY Day 24 Year 19 67

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 12/20/1888
9 AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY: HOME
11 BIRTHPLACE (County & State or foreign country): WEST VIRGINIA
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL P. TOWLER
14. MOTHER'S MAIDEN NAME: MOLLIE SIXEAS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16 SOCIAL SECURITY NO: NONE
17. INFORMANT: MRS. MARY J. GARRIS Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Thrombosis, aged and old — INTERVAL BETWEEN ONSET AND DEATH: unk.
DUE TO
(b): cerebral arteriosclerosis — unk
DUE TO
(c): arteriosclerosis, general — unk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardiovascular disease
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): No
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o'clock a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1967, to 24 July, 1967, that (I) (we) last saw the deceased alive on 24 July 1967, and that death occurred at 5:45 P.M. from causes and on the date stated above

22a. SIGNATURE: Clovis M. Snyder M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 25 July 67
22c. PHYSICIAN'S NAME (Type): CLOVIS M. SNYDER M.D.
22d ADDRESS: 106 N. POTOMAC ST. HAGERSTOWN MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7/26/67
23c NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEM.
23d LOCATION (City or Town) (County) (State): WASHINGTON D.C.

24 FUNERAL DIRECTOR ADDRESS: W. T. Rowent, Hagerstown, Md.
25a REC'D BY REGISTRAR DATE: JUL 28 1967
25b REGISTRAR'S SIGNATURE: Frances Yingler

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary please execute the certificate writing the word 'pending' in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10185 10182

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c LENGTH OF STAY IN 1b: D. O. A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 130 Ray St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Freddie — Middle Fahrney — Last Knodle
4 DATE OF DEATH: Month July — Day 30, — Year 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: August 18, 1916
9 AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months 11 Days 12
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Hauling
10b. KIND OF BUSINESS OR INDUSTRY: Trucking
11 BIRTHPLACE (State or foreign country): Hagerstown, Md.
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Harvey H. Knodle
14 MOTHER'S MAIDEN NAME: Ada V. Gorse

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16 SOCIAL SECURITY NO: 219-05-2960
17 INFORMANT: Mrs. Betty L. Knodle — Address: Hagerstown, Md. 130 Ray St.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease — Recent
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 7-31-67
Address (Street, city, town, or county): Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8- 2- 67
23c NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery
23d LOCATION (City or Town) (County) (State): Boonsboro, Md.

24 FUNERAL DIRECTOR — ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.
25a RECD BY REGISTRAR DATE: AUG 2 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10186

CERTIFICATE OF DEATH

10183

1 PLACE OF DEATH
a. COUNTY WASHINGTON
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c LENGTH OF STAY IN 1b 60 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MARYLAND b COUNTY WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
d STREET ADDRESS 51 EAST AVE.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First SADA Middle PEARL Last KRAMER
4. DATE OF DEATH Month JULY Day 7 Year 1967

5 SEX FEMALE
6. COLOR OR RACE WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1/6/1887
9 AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HIUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (County & State or foreign country) MARYLAND
12 CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME URIAH PALMER
14. MOTHER'S MAIDEN NAME MARY HESSONG

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16 SOCIAL SECURITY NO NONE
17 INFORMANT MRS. ESTHER CRAMER HAGERSTOWN MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO (b) Carcinoma of Stomach
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
151X
INTERVAL BETWEEN ONSET AND DEATH 4 months 8 months

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 66, 19__, to 7/7, 1967, that (I) (we) last saw the deceased alive on 6/30 1967, and that death occurred at 2:04 A M, from causes and on the date stated above.

22a SIGNATURE Geo. C. Jennings M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED 7/7/67
22c PHYSICIANS NAME (Type) GEORGE C. JENNINGS
22d ADDRESS 318 N. Potomac St Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL BURIAL
23b DATE THEREOF 7/9/67
23c NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.
23d LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.

24 FUNERAL DIRECTOR ADDRESS W. T. Norment, Hagerstown, Md.
25a RECEIVED BY REGISTRAR DATE JUL 11 1967
25b REGISTRAR'S SIGNATURE Charles Snook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10187

CERTIFICATE OF DEATH

10187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 **PLACE OF DEATH** — a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 43 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 134 WEST WASHINGTON
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: JOHN — Middle: SCOTT — Last: LANTZ
4. **DATE OF DEATH**: Month: JULY — Day: 19, — Year: 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 19, 1883
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): RETIRED INSURANCE AGENT.
10b. KIND OF BUSINESS OR INDUSTRY: INSURANCE BUSIN
11. BIRTHPLACE (County & State, or foreign country): AURORA, WEST VIRGINIA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: JOHN A. LANTZ
14. MOTHER'S MAIDEN NAME: OLIVE SCHAEFFER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 217-32-5066
17. INFORMANT: MRS. LENORA GLADWIN, Address: 8 ROESSNER AVENUE, HAGERSTOWN, MARYLAND.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Brain Syndrome — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO (b): Cerebral Arteriosclerosis — 11 months
DUE TO (c): Coronary Arteriosclerotic Heart Disease — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that (I) (the hospital) attended the deceased from 8-5-, 1966 to 7-19, 1967 that (I) (we) last saw the deceased alive on 7-19 1967, and that death occurred at 5:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Dalton M. Welty M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: JULY 21, 1967
22c. PHYSICIAN'S NAME (Type): DALTON M. WELTY, M.D.
22d. ADDRESS: 998 POTOMAC AVE. HAGERSTOWN, MARYLAND.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/22/67
23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY
23d. LOCATION (City or Town) (County) (State): HAGERSTOWN, WASH. CO. MD.

24. FUNERAL DIRECTOR — ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.
25a. RECD BY REGISTRAR DATE: JUL 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10185

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10185

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Weeks

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sharpsburg
d. STREET ADDRESS: Bloody Lane
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Alburtus — Last: Lohman

4. DATE OF DEATH: Month: July — Day: 14, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 24, 1883

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: 6 — Days: 20
IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Park Service

11. BIRTHPLACE (County & State, or Foreign country): Millers Sawmill, Wash. Co., Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: August Lohman

14. MOTHER'S MAIDEN NAME: Ida Moats

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 220-10-3752

17. INFORMANT: Mrs. Charlotte Lohman, Sharpsburg, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): UREMIC ACIDOSIS
DUE TO
(b): RENAL FAILURE
DUE TO
(c): POSSIBLE MYOCARDIAL INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE. SENILE DETERIORATION

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/1, 19 67 to 7/14, 19 67 that (I) (~~we~~) last saw the deceased alive on 7/14 19 67, and that death occurred at 4 30 P M, from causes and on the date stated above

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 7/16/67

22c. PHYSICIAN'S NAME (Type): RIZALITO AMARILLO

22d. ADDRESS: SHARPSBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7- 17- 1967

23c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

23d. LOCATION (City or Town) (County) (State): Sharpsburg, Md.

24. FUNERAL DIRECTOR: John H. Bast, Jr., 112 N. Main St. Boonsboro, Md

ADDRESS

25a. RECD BY REGISTRAR DATE: JUL 18 1967

25b. REGISTRAR'S SIGNATURE: [signature] Deputy Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10189

CERTIFICATE OF DEATH

10189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN To: 6 Mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Coffman Home for the Aging

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 210 Phylane Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA Middle: MAE Last: LUSHBAUGH

4. DATE OF DEATH: Month: Jluy Day: 26 Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 12 1883
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State or foreign country): Pa Charlestown Franklin
12. CITIZEN OF WHAT COUNTRY? Co USA

13. FATHER'S NAME: Jacob F. Bryan
14. MOTHER'S MAIDEN NAME: Mary Alice Hysong

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----
16. SOCIAL SECURITY NO.: 220-30-9095A
17. INFORMANT: Roy E. Lushbaugh Address: 210 Phylane Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hagerstown Md. Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: sev. days
DUE TO
(b): arteriosclerotic cardiovascular disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1962, to July, 1967 that (I) (we) last saw the deceased alive on July 24, 1967, and that death occurred at ____ M, from causes and on the date stated above

22a. SIGNATURE: Howard N Weeks M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/28/67
22c. PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.
22d. ADDRESS: 580 Northern Avenue Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/29/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc
ADDRESS: Hagerstown Md

25a. RECD BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10190 — 10187

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: ———

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 3
d. STREET ADDRESS: St James Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ANNIE Middle VIRGINIA Last MAY

4. DATE OF DEATH: Month July Day 11 Year 1967

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8 DATE OF BIRTH: Aug. 13-1885

9 AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months ——— Days ———
IF UNDER 24 HRS: Hours ——— Min ———

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (County & State, or foreign country): Frederick Co. Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John A. Roberts

14 MOTHER'S MAIDEN NAME: Elizabeth Tobery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ———

16. SOCIAL SECURITY NO.: Not available

17. INFORMANT Address: Mrs. Wm. C. Main- Rt. 3-Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Cerebral Arteriosclerosis
DUE TO
(c): ———

INTERVAL BETWEEN ONSET AND DEATH: Fatal

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/2/67, 19___, to 7/11/67, 19___, that (I) (we) last saw the deceased alive on 7/10/67 19___, and that death occurred at 9:25 AM, from causes and on the date stated above.

22a SIGNATURE: Robert V. h. Campbell M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/11/67

22c. PHYSICIAN'S NAME (Type): Robert V. h. Campbell

22d ADDRESS: HAGERSTOWN Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 14-1967

23c NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d LOCATION (City or Town) (County) (State): Frederick, Md. 21701

24. FUNERAL DIRECTOR: Frederick Md
ADDRESS: M.R. Etchison and Son By Edward T. Whitmore

25a. REC'D BY REGISTRAR DATE: JUL 13 1967

25b REGISTRAR'S SIGNATURE: [signature]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10191

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-Hancock
c. LENGTH OF STAY IN (b):
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Canada — b. COUNTY: Toronto Gore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bolton, Ontario
d. STREET ADDRESS: Lot 16 Concession 10
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Sylvester — Middle: Weare — Last: McGarvey

4 DATE OF DEATH: Month: July — Day: 24, — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: white

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 10, 1913

9 AGE (In years last birthday): 54 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): experimental

10b KIND OF BUSINESS OR INDUSTRY: aircraft mfg.

11. BIRTHPLACE (State or foreign country): Wearton, Ont., Can.

12 CITIZEN OF WHAT COUNTRY? Canada

13 FATHER'S NAME: William McGarvey

14 MOTHER'S MAIDEN NAME: Katherine McCartney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Matthew McGarvey, Toronto, Ont., Can. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Crushed chest
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Auto-auto collision

20c TIME OF INJURY Month, Day, Year, Hour a.m.: 12 noon 7/24 19 67

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Route 70 West of Hancock, Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Howard N Weeks M.D

EXAMINER'S NAME (Type): Howard N. Weeks, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 7/26/67

Address (Street, city, town or county): 580 Northern Ave. Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE THEREOF: 7-26-67

23c NAME OF CEMETERY OR CREMATORY: Toronto, Ont., Can.

23d LOCATION (City or Town) (County) (State): Toronto, Ont., Can.

24 FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md. — ADDRESS

25a RECD BY REGISTRAR DATE: JUL 31 1967

25b REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with (form) (PM). Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10192

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

-6189

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-Hancock
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Canada — b. COUNTY: Toronto Gore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bolton, Ontario
d. STREET ADDRESS: Lot 16 Concession 10
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Vera — Middle: — Last: McGarvery
4 DATE OF DEATH: Month: July — Day: 24, — Year: 1967

5 SEX: female
6 COLOR OR RACE: white
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 1913
9 AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): S. Porcupine, Ont. Can
12 CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME: Unknown
14 MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT — Address: Matthew McGarvery, Toronto, Ont., Can.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Auto-auto collision
20c TIME OF INJURY Month, Day, Year Hour a.m.: 12 noon 7/24 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f (City or town) (County) (State): Route 70 West of Hancock, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: H. N. Weeks M.D.
EXAMINER'S NAME (Type): Howard N. Weeks, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): 580 Northern Ave. Hagerstown, Md.
22. DATE SIGNED: 7/26/67

23a BURIAL, CREMATION, REMOVAL (Specify): removal
23b DATE THEREOF: 7-26-67
23c NAME OF CEMETERY OR CREMATORY: Toronto, Ont., Can.
23d LOCATION (City or Town) (County) (State): Toronto, Ont., Can.

24 FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home, Hagerstown, Md.
25a. REC'D BY REGISTRAR — DATE: JUL 31 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10193

CERTIFICATE OF DEATH

1013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Boonsboro
   c. LENGTH OF STAY IN 1b: 5 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fahrney-Keedy Memorial Home

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Frederick
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
   d. STREET ADDRESS: 211 W. Fifth Street
   • IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Blanche — Middle: — Last: McHenry

4. **DATE OF DEATH**: Month: 7 — Day: 9 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/13/1881

9. AGE (In years last birthday): 85 86 yrs. — IF UNDER 1 YEAR, Months: — Days: — IF UNDER 24 HRS. Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Frederick, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Henry McHenry

14. MOTHER'S MAIDEN NAME: Catherine Jane Crouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO. 213-24-9269

17. INFORMANT: Fahrney-Keedy Memorial Home — Address: Boonsboro, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia

DUE TO (b): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 7, 19.., to July 9, 19.., that (I) (we) last saw the deceased alive on July 7 19 67 and that death occurred at 3:30 P.M., from the causes and on the date stated above

22a. SIGNATURE: Dr H W Beahm M.D.S M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-10-67

22c. PHYSICIAN'S NAME (Type): Dr H W Beahm M.D.S

22d. ADDRESS: Boonsboro Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-11-1967

23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery

23d. LOCATION (City, town or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert E. Dailey & Son

ADDRESS: Frederick, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
20M 5 63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal. In any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10194 — 10191

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg — Rural
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD 1

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg — rural
d. STREET ADDRESS: RFD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Mary — Middle: Drusilla — Last: Miller
4 DATE OF DEATH: Month: July — Day: 25 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 28, 1884
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Foxville, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David C. Brown
14. MOTHER'S MAIDEN NAME: Sarah A. Lumm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 216-46-7677
17. INFORMANT — Address: Mrs. Alice Tracy, Smithsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Myocardial Degeneration — 1 1/2 yrs
DUE TO
(c): Senility of Contributory Causes — 15 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 21, 1967 to July 24 1967 that (I) (we) last saw the deceased alive on July 24 1967 and that death occurred at ____ M from causes and on the date stated above

22a. SIGNATURE: Geo E Kohler, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STATE PHYS ☐
22b DATE SIGNED: July 25 1967
22c PHYSICIAN'S NAME (Type): GEO. A KOHLER
22d ADDRESS: Smithsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
23d LOCATION (City or Town) (County) (State): Smithsburg Wash. Md.

24 FUNERAL DIRECTOR — ADDRESS: Minnich Funeral Home, Smithsburg, Md.
25a REC'D BY REGISTRAR DATE: JUL 28 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

19193 — 19193

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 70 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 716 SUNSET AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CHARLOTTE — Middle VERONA — Last MITCHELL

4 DATE OF DEATH: Month JULY — Day 30 — Year 67

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
FEMALE	WHITE	WIDOWED ☒	1/6/1892	75 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	WEST VIRGINIA	U.S.A.

13. FATHER'S NAME: MILLARD FILMORE REYNOLDS
14. MOTHER'S MAIDEN NAME: JULIA A. HOFFMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT — Address
NO	NONE	MRS. GAIL KERFOOT FRONT ROYAL VA.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): MALIGNANT LYMPHOMA(RETICULUM CELL CARCOMA — INTERVAL BETWEEN ONSET AND DEATH: 4-7-67
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensiva cardiovasc lar disease

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-7-67, 19___, to 7-30-67, 19___, that (I) (we) last saw the deceased alive on 7-30-67 19___, and that death occurred at 1:25A M, from causes and on the date stated above

22a. SIGNATURE: Sidney Novenstein M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-31-67
22c. PHYSICIAN'S NAME (Type): SIDNEY NOVENSTEIN, M. D.
22d. ADDRESS: FUNKSTOWN, MD.

23a BURIAL, CREMATION, REMOVAL	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	8/1/67	CEDAR LAWN MEM. PARK	HAGERSTOWN WASH. MD.

24 FUNERAL DIRECTOR — ADDRESS: W. T. Norment, Hagerstown Md.
25a REC'D BY REGISTRAR DATE AUG 2 1967
25b REGISTRAR'S SIGNATURE: Charles Yeager

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10196

CERTIFICATE OF DEATH

10196

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN To: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. Co. Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Wash
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Hagerstown
d. STREET ADDRESS: RD4 - Hagerstown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph; Middle: O.; Last: Moats

4 DATE OF DEATH: Month: July; Day: 15; Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 7/17/1882

9 AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a U.S.A. OCCUPATION (Give kind of work done during most of working life even if retired): Retired Farmer

10b KIND OF BUSINESS OR INDUSTRY: Farm

11 BIRTHPLACE (County & State, or foreign country): Tilghmanton, Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Moats

14 MOTHER'S MAIDEN NAME: Rebecca Rohrer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 198-30-4769

17 INFORMANT: Mrs. Carrie Moats — Address: Hagerstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Arteriosclerotic cardiovascular — 20 yrs.
(c): Angina
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1965 to 7/15, 1967, that (I) (we) last saw the deceased alive on 7/15/67, and that death occurred at 11:15 A.M. from causes and on the date stated above.

22a. SIGNATURE: W. C. Brewer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/17/67

22c PHYSICIAN'S NAME (Type): W. C. BREWER

22d. ADDRESS: GREENCASTLE, Penna.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7/18/67

23c NAME OF CEMETERY OR CREMATORY: Reiff Ch. Cem.

23d LOCATION (City or Town) (County) (State): near Cearfoss, Md.

24 FUNERAL DIRECTOR: A. E. Munnich

ADDRESS: Greencastle, Pa

25a RECD BY REGISTRAR DATE: JUL 19 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10197

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10197

1 PLACE OF DEATH
a COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c LENGTH OF STAY IN 1b: LIFE
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND — b COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 134 W. WASHINGTON ST.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First FRANCES — Middle VIRGINIA — Last MUMMERT
4. DATE OF DEATH: Month JULY — Day 25 — Year 19 67

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/21/1911
9 AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CASHIER
10b KIND OF BUSINESS OR INDUSTRY: LIFE INSURANCE CO.
11 BIRTHPLACE (County & State or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: CLARENCE GRUBER
14. MOTHER'S MAIDEN NAME: EDITH MYERS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16 SOCIAL SECURITY NO: 217-30-5563
17 INFORMANT: MR. LOREN R. MUMMERT — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: 5yrs
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/27, 19 64 to 7/25, 19 67, that (I) (we) last saw the deceased alive on 7/25 19 67, and that death occurred at 9:15 P.M. from causes and on the date stated above.

22a SIGNATURE: Donald E Martin — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7/27/67
22c. PHYSICIAN'S NAME (Type): Donald E. Martin, M.D.
22d. ADDRESS: 418 N. Potomac St., Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7/28/67
23c NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
23d LOCATION (City or Town): HAGERSTOWN (County): WASH. (State): MD.

24 FUNERAL DIRECTOR — ADDRESS: W. J. Norment, Hagerstown, Md.
25a. RECD BY REGISTRAR DATE: JUL 31 1967
25b REGISTRAR'S SIGNATURE: Charles Yingling

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10198 10198

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HAGERSTOWN
c LENGTH OF STAY IN 1b: LIFE
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 144 NORTH CANNON AVENUE

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MARYLAND
b COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HAGERSTOWN
d STREET ADDRESS: 144 NORTH CANNON AVENUE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First GUY; Middle CHARLES; Last MUSEY
4 DATE OF DEATH: Month JULY; Day 19; Year 1967
5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: NOV. 16, 1912
9 AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER
10b KIND OF BUSINESS OR INDUSTRY: GROCERY STORE
11 BIRTHPLACE (State or foreign country): HAGERSTOWN, MARYLAND.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.
13 FATHER'S NAME: JACOB E. MUSEY
14 MOTHER'S MAIDEN NAME: CLARA BELLE WHITE
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): *****
16. SOCIAL SECURITY NO: 218-30-9758
17 INFORMANT: MRS. NORMA S. MUSEY, 144 N. CANNON AVENUE, HAGERSTOWN, MARYLAND.

MED CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — Interval between onset and death: Instant
DUE TO
(b): Arteriosclerotic Heart Disease — Recent
DUE TO
(c):
4201
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year; Hour o.m. p.m.; 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town, (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward W. Ditto Jr. M.D.
EXAMINER'S NAME Type: EDWARD W. DITTO, JR. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 215 W. WASHINGTON ST. HAGERSTOWN, MARYLAND.
22 DATE SIGNED: 7/21/67

23a BURIAL CREMATION REMOVAL Specify: BURIAL
23b DATE THEREOF: 7/22/67
23c NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY
23d LOCATION (City or town) (County) (State): HAGERSTOWN, WASH. CO. MD.
24 FUNERAL DIRECTOR ADDRES: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.
25a RECD BY REGISTRAR DATE: JUL 25 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of Health prior to burial cremation, or removal, and in any event within 72 hours after death.

VR AI SME 15A 6M 67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10199

CERTIFICATE OF DEATH

1019?

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Pa. b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro Pa.
d. STREET ADDRESS: 17 N. Broad St.
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Anthony Last: Noel
4. DATE OF DEATH: Month: July Day: 19 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 7, 1892
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Florist
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Waynesboro Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Louis Noel
14. MOTHER'S MAIDEN NAME: Emma Brockley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 9/15/18 to 11/25/18)
16. SOCIAL SECURITY NO.: 179-36-3201
17. INFORMANT Address: Miss Certrude C. Noel, Waynesboro Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): arteriosclerotic vas-disease — 4 yrs
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia + diabetes
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 19 67 to July 19, 1967, that (I) (we) last saw the deceased alive on July 19 1967, and that death occurred at 6:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/20/67
22c. PHYSICIAN'S NAME (Type): H.N. WEEKS
22d. ADDRESS: 580 Northern Ave Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/22/67
23c. NAME OF CEMETERY OR CREMATORY: St. Andrews
23d. LOCATION (City or Town) (County) (State): Waynesboro, Franklin Pa.

24. FUNERAL DIRECTOR ADDRESS: Walter Y. Hoke Waynesboro, Pa.
25a. REC'D BY REGISTRAR DATE: JUL 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10200 — 10191

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Hagerstown
c. LENGTH OF STAY IN 1b: Six Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Avalon Manor Inc. Marsh Pike

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 8 Hill Crest Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: Rowe — Last: Null

4. DATE OF DEATH: Month: July — Day: 17 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/17/1884

9. AGE (In years last birthday): 82 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Rowe

14. MOTHER'S MAIDEN NAME: Frances M. Flenner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT: H. Richard Null, Address: 34 Hill Crest Ave. Waynesboro Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(b): Hypertensive cardio Vasc. Disease — yrs.
DUE TO
(c): Arterioscleros - Generalized — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 12, 1967 to July 17, 1967, that (I) (~~we~~) last saw the deceased alive on July 17 1967 and that death occurred at 2:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: Carol A. Hoffman — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/18/67

22c. PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22d. ADDRESS: 214 N. Potomac St. Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/20/67

23c. NAME OF CEMETERY OR CREMATORY: Green Hill

23d. LOCATION (City or Town) (County) (State): Waynesboro, Franklin, Pa.

24. FUNERAL DIRECTOR: Walter G. Grove — ADDRESS: Waynesboro, Pa.

25a. REC'D BY REGISTRAR DATE: JUL 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10201

CERTIFICATE OF DEATH

10198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN 1b: 2 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown Rfd. 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital	d. STREET ADDRESS: Mt. Lena Rd. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Charles	Edward	Paden	July	1,	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months	Days	If UNDER 24 HRS: Hours	Min
Male	White		March 2, 1907	60 yrs	3	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Maintenance	Air Craft	Hagerstown, Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Paden	Daisy Trovinger

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT Address
No.		Mrs. Ruth Paden, Rfd. 1 Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: less than 24 hours
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4281

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastrointestinal Bleeding — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that (I) this hospital) attended the deceased from Jan, 19 67 to July 1, 19 67, that (I) we) last saw the deceased alive on July 1, 19 67, and that death occurred at 8:28 A.M., from causes and on the date stated above.

22a. SIGNATURE	M.D	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22b DATE SIGNED
					6-3-67

22c PHYSICIAN'S NAME (Type)	22d ADDRESS
M.E. Byrkit	Williamsport Md

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	7-5-67	Pleasant Grove Cemetery	Sandy Mount, Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	JUL 7 1967	Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10202

CERTIFICATE OF DEATH

1C199

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL 1
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL 1
d. STREET ADDRESS: HANCOCK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARY — Middle VIOLA — Last PERCY

4 DATE OF DEATH: Month 7 — Day 24 — Year 1967

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
F	W	WIDOWED ☒	9.2.1894	72 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		BARNHILL OHIO	U.S.A.

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
WILLIAM E MILLER	SARAH GARABRANDT

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT Address
NO		ROBERT PERCY RURAL 1 HANCOCK MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO (b) ASHD — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Gen Arteriosclerosis — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Bronchitis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/15/67, 19__, to 11/1, 19 66 that (I) (we) last saw the deceased alive on 11/1 19 66, and that death occurred at 10:30 AM, from causes and on the date stated above.

22a SIGNATURE: F B Thomas III M.D. — M.D. — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS ☐
22b DATE SIGNED: 7/24/67
22c. PHYSICIAN'S NAME (Type): F B Thomas III M.D.
22d. ADDRESS: Hancock, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	7.28.67	E.AVE.NEW PHILLA CEM.	E.AVE.NEW PHILLA OHIO

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Howard F Shaw	Hancock Md	JUL 28 1967	Frances Yingling

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7-62

1. PLACE OF DEATH — a. COUNTY: Washington — b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN Md.: 1 week — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Frederick — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lantz — d. STREET ADDRESS: RD 1 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harvey — Middle E. — Last Pryor

4. DATE OF DEATH: Month July — Day 7 — Year 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 16, 1891

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Machine Co.

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Pryor

14. MOTHER'S MAIDEN NAME: Amanda Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-7073

17. INFORMANT: Emma G. Pryor — Address: Lantz, Md. RD 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Arteriosclerotic cardiovascular disease — 5 years

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-24, 1962 to 7-7, 1967, that (I) (we) last saw the deceased alive on 7-7, 1967, and that death occurred at 3:45 PM, from the causes and on the date stated above

22a. SIGNATURE: Charles F. Hess M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7-7-67

22c. PHYSICIAN'S NAME (Type): Charles F. Hess, M.D. — 22d. ADDRESS: Smithsburg, Maryland 21783

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 7-10-67 — 23c. NAME OF CEMETERY OR CREMATORY: Germantown Ch. of God — 23d. LOCATION (City, town or county): Cascade Md. (State): Fred. Co

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager — ADDRESS: Raymond E. Creager Thurmont, Md. — 25a. REC'D BY REGISTRAR: JUL 10 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Yingst

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10204 — 10201

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 52 Wayside Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Glen Middle: Grove Last: Rebok

4. DATE OF DEATH: Month: July Day: 10, Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-11-96

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: aircraft mfg.

11. BIRTHPLACE (County & State, or foreign country): Franklin Co., Penna.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 155-01-0844

17. INFORMANT Address: Glen G. Rebok, Jr., Aurora, Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSUS — INTERVAL BETWEEN ONSET AND DEATH: 11 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE — UNKNOWN
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 07/01/67, 19 to 07/10/67, 19, that (I) (we) last saw the deceased alive on 07/10/67, 19, and that death occurred at 1:55 PM, from the causes and on the date stated above.

22a. SIGNATURE: Archie Robert Cohen M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 07/11/67

22c. PHYSICIAN'S NAME (Type): ARCHIE ROBERT COHEN M.D.

22d. ADDRESS: CLEARSPRING, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-14-67

23c. NAME OF CEMETERY OR CREMATORY: Gettysburg Nat. Cem.

23d. LOCATION (City, town or county) (State): Gettysburg, Penna.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md.

25a. RECD BY REGISTRAR DATE: JUL 13 1967

25b. REGISTRAR'S SIGNATURE

JUL 13 1967

VR A15 (4)
20M 1/65

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10205

CERTIFICATE OF DEATH

10202

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 424 Mitchell Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Frankie — Middle: Lynn — Last: Ricker

4 DATE OF DEATH: Month: July — Day: 5 — Year: 1967

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8 DATE OF BIRTH: July 4, 1967

9 AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: 3 — Min: 54

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.

12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Richard Lee Ricker

14 MOTHER'S MAIDEN NAME: Mary Anna Wallech

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO.: None

17 INFORMANT — Address: Mr. R.L. Ricker 424 Mitchell Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE
DUE TO (b): PREMATURITY
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year — Hour o m. p m. — 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4 July, 1967, to 5 July, 1967, that (I) (we) last saw the deceased alive on 5 July 1967, and that death occurred at 2 AM, from causes and on the date stated above.

22a SIGNATURE: [signature] — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6 July 1967

22c PHYSICIAN'S NAME (Type): W. N. FENDER

22d ADDRESS: 216 N. Potomac St. Hagerstown, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7/6/67

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d LOCATION (City or Town) (County) (State): Hagerstown Washington Md

24 FUNERAL DIRECTOR: Wm. G. Hoot — **ADDRESS**: Rest Haven Funeral Chapel Hagerstown, Md.

25c. REC'D BY REGISTRAR DATE: JUL 10 1967

25d. REGISTRAR'S SIGNATURE: [signature]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10206 10203

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY Washington MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville
c. LENGTH OF STAY IN 1b —
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maugansville, Md

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE Md b COUNTY Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville
d STREET ADDRESS 216 North St
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Jacob Middle H. Last Risser
4 DATE OF DEATH Month July Day 8 Year 1967

5 SEX M
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH Feb 13 1880
9. AGE (In years last birthday) 87 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b KIND OF BUSINESS OR INDUSTRY Retired
11 BIRTHPLACE (County & State, or foreign country) Washington Co Md
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Risser
14. MOTHER'S MAIDEN NAME Barbara Martin

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No
16. SOCIAL SECURITY NO 220-18-1939
17 INFORMANT Anna Risser Address Maugansville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH 10 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatoid Arthritis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/4 19 67 to 7/ 65, that (I) (we) last saw the deceased alive on 6/20 1967, and that death occurred at 0.00 M, from causes and on the date stated above.

22a SIGNATURE Donald E. Martin M.D ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED 7/11/67
22c PHYSICIAN'S NAME (Type) DONALD E. MARTIN, M.D
22d ADDRESS 718 N. Potomac St, Hag, Wash, Md.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 7/12/67
23c NAME OF CEMETERY OR CREMATORY Reiff Ch. Cem.
23d LOCATION (City or Town) near Cearfoss, Md. (County) (State)

24 FUNERAL DIRECTOR A. E. Munnich - Greencastle Pa. ADDRESS
25a RECD BY REGISTRAR DATE JUL 13 1967
25b REGISTRAR'S SIGNATURE [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10207

CERTIFICATE OF DEATH

10204

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BREATHEDSVILLE
d STREET ADDRESS: None RD. BOONSBORO, MD.
e S RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First BESSIE — Middle SOUTH — Last ROUTZAHN
4 DATE OF DEATH: Month JULY — Day 11 — Year 1967

5. SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/5/1882
9 AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months 1 — Days 6
IF UNDER 24 HRS: Hours — Min.

N

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): WASHINGTON Co., MD
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN GEARY SOUTH
14 MOTHER'S MAIDEN NAME: JANE C ADAMS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 215-48-5623
17 INFORMANT: ISABELLE A. GEHR — Address: HAGERSTOWN, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of Transverse Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b): Metastases to liver — 6 mos
DUE TO (c): Intestinal Obstruction — 1 wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1531

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 6, 1967, to July 11, 1967, that (I) (we) last saw the deceased alive on July 11 1967, and that death occurred at 5:45 A.M., from causes and on the date stated above.

22a SIGNATURE: John A. Moran M.D. MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED:
22c PHYSICIAN'S NAME (Type): JOHN A. MORAN M.D.
22d ADDRESS: HAGERSTOWN, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7/14/67
23c NAME OF CEMETERY OR CREMATORY: BEAVER CREEK CEMETERY
23d LOCATION (City or Town) (County) (State): BEAVER CREEK WASH. MD.

24 FUNERAL DIRECTOR: HOWARD J. GROVE — ADDRESS: HANCOCK, MARYLAND
25a. REC'D BY REGISTRAR — DATE: JUL 17 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10208

CERTIFICATE OF DEATH

10205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clear Spring, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Mill St.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clear Spring, Md.
d. STREET ADDRESS: Mill St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: Emma — Last: Routzahn

4. DATE OF DEATH: Month: July — Day: 10, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1,1906

9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Home duties

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John B. Walfkill

14. MOTHER'S MAIDEN NAME: Lula Grossnickle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: None

17. INFORMANT: Willis Routzahn — Address: Clear Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocardial Infarction — 5 minutes
DUE TO (c): Coronary artery atherosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 07/18/66, 19___, to 07/10/66, 19___, that (I) (we) last saw the deceased alive on 07/10/66 19___, and that death occurred at 4:30A.M. from causes and on the date stated above.

22a. SIGNATURE: Archie Robert Cohen — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 07/11/67

22c. PHYSICIAN'S NAME (Type): Archie Robert Cohen M.D.

22d. ADDRESS: Clear Spring, Maryland 21722

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/12/67

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cem.

23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR: Margaret Rowland — ADDRESS: Clear Spring, Md.

25a. RECD BY REGISTRAR, DATE: JUL 13 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 55 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 629 Pennsylvania Ave.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 629 Pennsylvania Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Sonta — Middle: Lorraine — Last: Schaff
4 DATE OF DEATH: Month: July — Day: 8 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: March 18, 1905
9 AGE (In years last birthday): 62 yrs
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician
10b KIND OF BUSINESS OR INDUSTRY: Entertainment
11 BIRTHPLACE (State or foreign country): Upton, Penna.
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: George Harris Schaff
14 MOTHER'S MAIDEN NAME: Sarah Spielman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 217-10-3447
17 INFORMANT: Philip L. Schaff — Address: 629 Pennsylvania Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arteriosclerotic heart disease
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic alcoholism

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Howard N. Weeks M.D.
EXAMINER'S NAME (Type): Howard N. Weeks, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED
Address (Street, city, town or county): 580 Northern AVe. Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/12/67
23c NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d LOCATION (City or Town) (County) (State): Hagerstown, Washington, Md.

24 FUNERAL DIRECTOR: Wm. C. Horst — ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.

25a RECD BY REGISTRAR DATE: JUL 12 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10210 — 10207

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 38 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. WASHINGTON CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: ROOM 202 HAMILTON HOTEL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RUDOLPH — Middle: ADOLPH — Last: SCHULTZ

4. DATE OF DEATH: Month: JULY — Day: 7, — Year: 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 28, 1885
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHEF
10b. KIND OF BUSINESS OR INDUSTRY: HOTEL BUSINESS
11. BIRTHPLACE (County & State, or foreign country): VOLYNIA, RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RINEHART SCHULTZ
14. MOTHER'S MAIDEN NAME: WIELAHMENIA CROSER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): ***
16. SOCIAL SECURITY NO: 214-09-2263A
17. INFORMANT: MR. ALVIN KRAUSE, QUAKERTOWN, PENNSYLVANIA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Arteriosclerotic heart disease — yrs
DUE TO (c): Generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes and obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): none
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: none 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town) (County) (State): - - -

21. **I certify** that (I) (the hospital) attended the deceased from Dec, 1962, to July, 1967, that (I) (we) last saw the deceased alive on June 21 19 67 and that death occurred at ___ A.M. from causes and on the date stated above

22a. SIGNATURE: Harold R Tritch Jr — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: JULY 10, 1967
22c. PHYSICIAN'S NAME (Type): HAROLD R. TRITCH, JR. M.D.
22d. ADDRESS: 302 N. POTOMAC ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/13/67
23c. NAME OF CEMETERY OR CREMATORY: KELLERS CHURCH CEMETERY
23d. LOCATION (City or Town) (County) (State): KELLERS CHURCH, BUCKS CO. PA.

24. FUNERAL DIRECTOR ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.
25a. REC'D BY REGISTRAR DATE: JUL 14 1967
25b. REGISTRAR'S SIGNATURE: Charles Yingst

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10211

CERTIFICATE OF DEATH

1380 2

PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Hagerstown
d. STREET ADDRESS: RFD 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frances Middle Violet Last Sheppard
4. DATE OF DEATH: Month July Day 4, Year 1967
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-20-02
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Albert H. Middlekauff
14. MOTHER'S MAIDEN NAME: Virgie Hoch
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-09-9109B
17. INFORMANT: Address: Carl H. Sheppard, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pneumonitis
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2 Wks.
493X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Athero-Sclerosis. Hypertension Cardiac Failure
WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~was hospital~~) attended the deceased from June 24, 1967 to July 4, 1967 that (I) (~~saw~~) last saw the deceased alive on July 4 1967, and that death occurred at 4 P.M. from causes and on the date stated above.

22a. SIGNATURE: J H Beachley M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: July 5/67
22c. PHYSICIAN'S NAME (Type): J H Beachley
22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-6-67
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home, ADDRESS Hagerstown, Md.
25a. RECD BY REGISTRAR DATE JUL 7 1967
25b. REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10212

CERTIFICATE OF DEATH

10299

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN To
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Homewood Church Home Inc

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md — b. COUNTY: Wash
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clear Spring
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Bertha — Middle: L. — Last: Shirk

4 DATE OF DEATH: Month: July — Day: 20, — Year: 1967

5 SEX: F — 6. COLOR OR RACE: W — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8 DATE OF BIRTH: Oct 6, 1880 — 9 AGE (In years last birthday): 87 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b KIND OF BUSINESS OR INDUSTRY: Housewife
11 BIRTHPLACE (County & State, or foreign country): Big Pool Md
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: John L. Murray
14. MOTHER'S MAIDEN NAME: Deliliah Tedrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO: 215-36-6037A
17 INFORMANT: Mark S. Wagner, Supt. — Address: Womelsdorf, 21795

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b): —
DUE TO
(c): Hypertensive C V Dis — 8 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept, 1965 to July 20, 1967 that (I) (we) last saw the deceased alive on July 13 1967, and that death occurred at 4 A M, from causes and on the date stated above

22a. SIGNATURE: Robert P Conrad M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 7-20-67
22c. PHYSICIAN'S NAME (Type): Robert P. Conrad — 22d ADDRESS: Hagerstown, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 7-23-67 — 23c NAME OF CEMETERY OR CREMATORY: Shankstown Cemetery — 23d LOCATION (City or Town) (County) (State): Big Pool, Md.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md. — ADDRESS
25a. REC'D BY REGISTRAR DATE: JUL 24 1967 — 25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10213

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 YEARS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARTIN MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND — b COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BIG POOL
d STREET ADDRESS: BIG POOL
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First FRANK — Middle OTHO — Last SHIVES
4 DATE OF DEATH: Month JULY — Day 23 — Year 67

5 SEX: WHITE
6 COLOR OR RACE: MALE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 12/27/1890
9 AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STORE CLERK
10b KIND OF BUSINESS OR INDUSTRY: GOVERNMENT
11 BIRTHPLACE (County & State, or foreign country): WASHINGTON, MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS W. SHIVES
14. MOTHER'S MAIDEN NAME: SUSAN ISABELLE BEARD

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16 SOCIAL SECURITY NO: 220-16-3413
17 INFORMANT: MR. EARL SHIVES — Address: BIG POOL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.
44 5X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Disease — unknown
DUE TO (c): Unknown

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒ XX

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 22, 1967, to July 23, 1967, that (I) (we) last saw the deceased alive on July 23 1967, and that death occurred at 4:50PM from causes and on the date stated above.

22a SIGNATURE: William T. Layman, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c PHYSICIAN NAME (Type): William T. Layman,
22d ADDRESS: 100 Professional Arts Building Hagerstown, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7/25/67
23c NAME OF CEMETERY OR CREMATORY: PARKHEAD E.U.B.
23d LOCATION (City or Town) (County) (State): BIG POOL WASH., MD.

24. FUNERAL DIRECTOR: Howard F. Hose Hancock Md. — ADDRESS
25a REC'D BY REGISTRAR DATE: JUL 28 1967
25b REGISTRAR'S SIGNATURE: Charles Snyder

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10214

CERTIFICATE OF DEATH

10211

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Pa. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Chambersburg
d. STREET ADDRESS: RD8 - Chambersburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HIRAM Middle E. Lost SHUPP
4. DATE OF DEATH: Month July Day 17 Year 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 7, 1874
9. AGE (In years last birthday): 92 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): Clearspring, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Shupp
14. MOTHER'S MAIDEN NAME: Sayllie Weller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 201-18-1654
17. INFORMANT: Mrs Lietz White RD8 Address: Chambersburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral hemorrhage → INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerotic cardiovascular
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): disease → 20 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7/6, 19__, to 7/17, 1967, that (I) (we) last saw the deceased alive on 7/17 1967, and that death occurred at 3:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Wm C Brewer — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/18/67
22c. PHYSICIAN'S NAME (Type): Wm C. Brewer
22d. ADDRESS: Greencastle, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/20/67
23c. NAME OF CEMETERY OR CREMATORY: Reiff Ch. Cem.
23d. LOCATION (City or Town) (County) (State): Cearfoss Md.

24. FUNERAL DIRECTOR: C.E. Wunch — ADDRESS: Greencastle, Pa.
25b. REC'D BY REGISTRAR DATE: JUL 20 1967
25c. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10215 — 10213

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c LENGTH OF STAY IN 1b: 1 DAY
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a STATE: MARYLAND — b COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d STREET ADDRESS: WASHINGTON
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

79

3 NAME OF DECEASED (Type or print): First: DIANE — Middle: MARIE — Last: SINNER
4 DATE OF DEATH: Month: JULY — Day: 8, — Year: 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 7, 1967
9. AGE (In years last birthday): **** yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours 11 — Min 30

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b KIND OF BUSINESS OR INDUSTRY: NONE
11 BIRTHPLACE (County & State, or foreign country): WASHINGTON CO. MARYLAND.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: STEWARD L. SINNER
14. MOTHER'S MAIDEN NAME: DORIS CEARFOSS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): ***
16 SOCIAL SECURITY NO: N/A
17 INFORMANT: MR. STEWARD L. SINNER, Address: 55 VALLEY DRIVE, HAGERSTOWN, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH: none
DUE TO (b): Premat Lung
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 7, 1967, to July 8, 1967, that (I) (we) last saw the deceased alive on July 8 1967, and that death occurred at 1:20 PM, from causes and on the date stated above.

22a SIGNATURE: Harold H Gist M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: JULY 10, 1967
22c. PHYSICIAN'S NAME (Type): HAROLD H. GIST, M.D.
22d. ADDRESS: 214 N. POTOMAC ST. HAGERSTOWN, MARYLAND.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/11/67
23c NAME OF CEMETERY OR CREMATORY: MT. TABOR LUTH. CHURCH CEM.
23d LOCATION (City or Town) (County) (State): RURAL HAGERSTOWN, WASH. CO.

24 FUNERAL DIRECTOR ADDRESS: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.

25a REC'D BY REGISTRAR DATE: JUL 14 1967
25b REGISTRAR'S SIGNATURE MD.: Charles Yingling

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10216

CERTIFICATE OF DEATH

10213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland — b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN 1b: 1 Week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rohrersville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital	d. STREET ADDRESS: Rfd. 1 — e. RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Garley — Middle: Roosevelt — Last: Smith	4. DATE OF DEATH: Month: July — Day: 3, — Year: 19 67
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: July 4, 1902 — 9. AGE (In years last birthday): 64 yrs — IF UNDER 1 YEAR: Months 11, Days 29 — IF UNDER 24 HRS: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Labor — 10b. KIND OF BUSINESS OR INDUSTRY: Co. Road Dept. — 11. BIRTHPLACE (County & State, or foreign country): Rural Rohrersville, Md. — 12. CITIZEN OF WHAT COUNTRY?: U. S. A.	
13. FATHER'S NAME: George E. Smith — 14. MOTHER'S MAIDEN NAME: Emma Seigler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No. — 16. SOCIAL SECURITY NO: 213-12-7222 — 17. INFORMANT: Mrs. Clara M. Smith, Rfd. 1 Rohrersville, Address: Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): subdural hematoma — INTERVAL BETWEEN ONSET AND DEATH: 20 days
DUE TO
(b): viscerotubulary hemia
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): hiatal hernia & gastric ulcer — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above

22a. SIGNATURE: H. N. Wertz M.D. — M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): H.N. Wertz M.D. — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 7- 6- 67	23c. NAME OF CEMETERY OR CREMATORY: Locust Grove Cemetery	23d. LOCATION (City or Town) (County) (State): Locust Grove, Wash. Md.
24. FUNERAL DIRECTOR — ADDRESS: John H. Bast, Jr. 112 N. Main St. Boonsboro, Md		25a. RECD BY REGISTRAR — DATE: JUL 7 1967	25b. REGISTRAR'S SIGNATURE: Charles Snaze

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10217

CERTIFICATE OF DEATH

10214

1 PLACE OF DEATH
a. COUNTY: WASHINGTON
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c LENGTH OF STAY IN 1b: 2 WEEKS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MARYLAND
b. COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HANCOCK
d STREET ADDRESS: RFD #2
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First IRA Middle SAMUEL Last SMITH
4 DATE OF DEATH: Month JULY Day 22 Year 19 67

5 SEX: MALE
6. COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/25/1876
9. AGE (In years last birthday): 90 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~XXXX~~ FARMING
10b KIND OF BUSINESS OR INDUSTRY: FARM
11 BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: PHILLIP SAMUEL SMITH
14. MOTHER'S MAIDEN NAME: MARTHA MORGAN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 182-40-5270
17. INFORMANT Address: ROSA E. SMITH, RFD #2, HANCOCK, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Diabetes Mellitus — 4 yrs
DUE TO (c): Diabetic gangrene 2nd & 3rd left toes — 1 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis; senility
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 10th, 1967 to July 22, 1967 that (I) (we) last saw the deceased alive on July 22, 1967, and that death occurred at 6:30 PM, from causes and on the date stated above

22a. SIGNATURE: John A. Moran M.D ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/25/67
23c NAME OF CEMETERY OR ~~CREMATORY~~: ANTIOCH CHRISTIAN
23d LOCATION (City or Town) (County) (State): FULTON CO; PENNSYLANNIA

24. FUNERAL DIRECTOR: Howard J. Hess
ADDRESS: Hancock Md
25a REC'D BY REGISTRAR DATE JUL 28 1967
25b REGISTRAR'S SIGNATURE: Charles Yeager

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10218 10216

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 9 Mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Homewood Church Home Inc

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 306 Turnbridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First BERTHA — Middle G — Last SPENCE

4 DATE OF DEATH: Month July — Day 9 — Year 1967

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	White	WIDOWED ☒	Oct 30 1890	76 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Baltimore City Md	USA

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Charles Davis Garner	Elizabeth Anne Roemer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT	Address
No	-----	218-30-6232	Mark G. Wagner	2750 Virginia Ave Williamsport Md. 21795

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 14, 1966 to 7-9, 1967 that (I) (we) last saw the deceased alive on 7-6 1967, and that death occurred at 10 P.M. from causes and on the date stated above.

22a. SIGNATURE: Robert F. Conrad M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7-10-67
22c. PHYSICIAN'S NAME (Type): Robert F. Conrad
22d. ADDRESS: Hagerstown, Md

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	7/13/67	Baltimore Cemetery	Baltimore City Md.

24 FUNERAL DIRECTOR: Andrew K. Coffman Funeral Home Inc — ADDRESS: Hagerstown Md

25a. REC'D BY REGISTRAR DATE: JUL 11 1967 — 25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10219 Items 1-9 Film 6 10 7/17/67 kk 10217

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 M

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Washington
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md. — c LENGTH OF STAY IN 1b: 24 hrs.	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clear Spring, Md.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital	d STREET ADDRESS: Rural 2 — e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Daisy	Reed	Steele	July	7	19 67

5 SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Female	White		9/24/1893 Unknown	73 Unknown		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Home Duties	House work	Unknown	U.S.A.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT Address
No — None	220-54-3623T	Daniel Reed Hancock, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	prob. myocardial infarction	5 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	coronary insufficiency	years
DUE TO		
(c)	generalized arteriosclerosis	years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): emphysema

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5 July, 19___, to death, 19___, that (I) (we) last saw the deceased alive on 7 July 19 67, and that death occurred at ___M, from causes and on the date stated above.

22a SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
John C. Stauffer		
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS	

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/10,67	Rose Hill Cem.	Hagerstown, Md.

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Maynard Rowland	Clear Spring, Md.	JUL 11 1967	Charles Junge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10220

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND. b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRPLAY
d. STREET ADDRESS: FAIRPLAY R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First TAMMY Middle SUE Last STEVENS
4 DATE OF DEATH: Month JULY Day 22 Year 1967

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB-11-1967
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months 5 Days 11
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State or foreign country): HAGERSTOWN WASH. Co. MD. U.S.A.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: EDWARD STEVENS
14 MOTHER'S MAIDEN NAME: BONNIE KERSHNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: EDWARD STEVENS FAIRPLAY MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): ASPIRATION PNEUMONIA
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MULTIPLE CONGENITAL ANOMALY
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/17, 1967 to 7/22, 1967, that (I) (we) last saw the deceased alive on 7/22 1967, and that death occurred at 11:30 PM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/24/67
22c. PHYSICIAN'S NAME (Type): RIZALITO AMARILLO
22d. ADDRESS: SHARPSBURG, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7-25-1967
23c NAME OF CEMETERY OR CREMATORY: GREEN LAWN CEMETERY
23d LOCATION (City or Town) (County) (State): WILLIAMSPORT WASH. Co. MD

24. FUNERAL DIRECTOR: John H. Bast Sr.
ADDRESS: BOONSBORO MD.
25a RECD BY REGISTRAR DATE: JUL 26 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10221 — 10219

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HANCOCK
   c. LENGTH OF STAY IN 1b: 25 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD #1, HANCOCK, MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If institution Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HANCOCK
   d. STREET ADDRESS: RFD #1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First RUTH — Middle BROOK — Last TANEYHILL

4. **DATE OF DEATH**: Month JULY — Day 12 — Year 67

5. SEX: F

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 5/22/1887

9. AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE H. BROOK

14. MOTHER'S MAIDEN NAME: ADA TAYLOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: 217-36-0568

17. INFORMANT — Address: JAMES R. BROOK RD. RD#1 HANCOCK, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO (b): Atherosclerotic Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 10, 1967, to July 12, 1967, that (I) (we) last saw the deceased alive on July 10 1967, and that death occurred at 9:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Charles R. Wierer, M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 7-12-67

22c. PHYSICIAN'S NAME (Type): CHARLES R. WIERER

22d. ADDRESS: HANCOCK, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/15/67

23c. NAME OF CEMETERY OR CREMATORY: CATALPA METHODIST

23d. LOCATION (City or Town) (County) (State): RURAL HANCOCK MD.

24. FUNERAL DIRECTOR: Richard F. Grove — ADDRESS: Hancock Md.

25a. REC'D BY REGISTRAR — DATE: JUL 17 1967 — REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16222 — 1067

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): #1 RFD Williamsport
d. STREET ADDRESS: RFD #1 Williamsport
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CEORGE — Middle: CLAIR — Last: TRUITT Sr.

4. DATE OF DEATH: Month: July — Day: 16 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 25 1908

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months: 0 Days: 20 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Lumber & Supplies

11. BIRTHPLACE (County & State, or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Samuel Truitt [illegible]

14. MOTHER'S MAIDEN NAME: Ida Mae Bixler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): --------

16. SOCIAL SECURITY NO.: 215-03 8202

17. INFORMANT: Mrs. Lillian D. Truitt — Address: Williamsport Md. RFD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): massive post. lateral infaction
DUE TO (b): Rt. coronary occlusion
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 min / ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1963, to July 16, 1967, that (I) (we) last saw the deceased alive on July 16 1967 and that death occurred at 2:20 PM, from the causes and on the date stated above.

22a. SIGNATURE: Max E Byrkit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-17-67

22c. PHYSICIAN'S NAME (Type): Max E. Byrkit M.D.

22d. ADDRESS: Williamsport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 19-67

23c. NAME OF CEMETERY OR CREMATORY: Lorrain Cemetery

23d. LOCATION (City, town or county) (State): Baltimore Maryland

24. FUNERAL DIRECTOR: Albert L. Leaf — ADDRESS: Williamsport, Md.

25a. REC'D BY REGISTRAR DATE: JUL 19 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR 415 (4)
20M 1/65

1

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then clean carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR AIS (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10223 — 10221

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Avalon Manor Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Schuylkill
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RD #1, Ashland
d. STREET ADDRESS: RD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Joseph — Last: Wagner

4. **DATE OF DEATH**: Month: July — Day: 13 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 2 1885

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Road work

11. BIRTHPLACE (County & State, or foreign country): Schuylkill Co. Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Z Wagner

14. MOTHER'S MAIDEN NAME: Sarah Bixler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 185-09-6428

17. INFORMANT: Mrs John L. Stone — Address: Hancock 6, Pa

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO (b): Arteriosclerosis - Generalized — 2 yrs +

DUE TO (c): Diabetes Mellitus — 2 yrs +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Feb 17, 1966 to July 13, 1967, that (I) (we) last saw the deceased alive on July 13, 1967, and that death occurred at 4:15 P.M. from the causes and on the date stated above

22a. SIGNATURE: Lloyd A. Hoffman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Lloyd A Hoffman

22d. ADDRESS: Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/16/1967

23c. NAME OF CEMETERY OR CREMATORY: St Johns Cemetery

23d. LOCATION (City, town or county) (State): Ashland, Schuylkill Co Pa

24 FUNERAL DIRECTOR'S SIGNATURE: Harold M. Simmons — ADDRESS: Hancock Md

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

Items 18&21 Form 390 7-20

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10224

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12822

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 a. PLACE OF DEATH — COUNTY: WASHINGTON COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANCOCK
c. LENGTH OF STAY IN b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Warfordsburg Road near Hancock

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: PENNSYLVANIA b. COUNTY: Fulton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warfordsburg
d. STREET ADDRESS: Rural Warfordsburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First HAYES Middle EMANUEL Last WARD
4 DATE OF DEATH: Month JULY Day 9 Year 1967

5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 6/26/1915
9 AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b KIND OF BUSINESS OR INDUSTRY: N.A.
11 BIRTHPLACE (State or foreign country): PENNSYLVANIA
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: AMOS WARD
14. MOTHER'S MAIDEN NAME: ORA SCRIEVER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): W.W. 2
16. SOCIAL SECURITY NO.: 054-14-4643
17 INFORMANT — Address: ALFRETTA L. WARD WARFORDSBURG, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Alcoholism With Exposure — INTERVAL BETWEEN ONSET AND DEATH: Several hours.
DUE TO (a) Acute alcoholism (Blood 0.21 per cent ethyl alcohol)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO (b) (b) Aspiration of Vomitus
DUE TO (c) (c) Chronic alcoholism with exposure

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Patient has been a very usen of alcohol.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: A. W. Ditto M.D.
EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 7-10-67
Address (Street, city, town, or county): Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7/13/67
23c. NAME OF CEMETERY OR CREMATORY: BUCK VALLEY METHODIST
23d LOCATION (City or Town) (County) (State): WARFORDSBURG FULTON, PA.

24 FUNERAL DIRECTOR — ADDRESS: Richard J. Snowe Hancock, Md.
25a. RECD BY REGISTRAR — DATE: JUL 17 1967
25b REGISTRAR'S SIGNATURE: Beverly Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10225

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md.
c. LENGTH OF STAY IN 1b: 40yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Maryland
d. STREET ADDRESS: 341 Suter Alley.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Elizabeth — Last: Washington

4. DATE OF DEATH: Month: July — Day: 12 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 29 1905
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Private family
11. BIRTHPLACE (County & State, or foreign country): Markham, Va.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Dan Washington
14. MOTHER'S MAIDEN NAME: UNknow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO: 216-303543
17. INFORMANT — Address: Mrs. Mary Johnson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 16 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Ca of Sigmoid Colon — 4 mos
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Right hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDER. ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6/26/67, 19___ to 7/12/67, 19___, that ( ) (we) last saw the deceased alive on 7/12/67 19___, and that death occurred at 5:10 P.M. from causes and on the date stated above.

22a. SIGNATURE: John A. Moran, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/12/67
22c. PHYSICIAN'S NAME (Type): John A. Moran, M.D.
22d. ADDRESS: 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-20-1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriis
23d. LOCATION (City or Town) (County) (State): Hume, Va.

24. FUNERAL DIRECTOR — ADDRESS: John R Watson Jr. Hagerstown Md.
25a. RECEIVED BY REGISTRAR DATE: JUL 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10226

CERTIFICATE OF DEATH

10224

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c LENGTH OF STAY IN 1b: 49 yrs.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 203 West Side Ave.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland
b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 203 West Side Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Doc — Middle: Joseph — Last: Weaver

4 DATE OF DEATH: Month: July — Day: 27 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Dec. 5, 1892

9 AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: Flour Mill

11. BIRTHPLACE (County & State, or foreign country): Bentonville, Va.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ernest Powell Weaver

14. MOTHER'S MAIDEN NAME: Alice Clarinda Matthews

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16 SOCIAL SECURITY NO: 214-09-3068

17 INFORMANT: Mrs. Mary C. Weaver — Address: Hagerstown, Md. 203 West Side Ave.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia
DUE TO (b): adenocarcinoma of prostate with metastasis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): None

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: none 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f (City or town) (County) (State): - - -

21. I **certify** that (I) (this hospital) attended the deceased from March, 1962, to July, 19 67 that (I) (we) last saw the deceased alive on July 14 19 67, and that death occurred at P. M. from causes and on the date stated above

22a. SIGNATURE: Harold R Tritch Jr M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-28-67

22c PHYSICIAN'S NAME (Type): Dr. Harold R. Tritch, Jr M.D.

22d ADDRESS: 302 N. Potomac St Hagerstown, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7/30/67

23c NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d LOCATION (City or Town) (County) (State): Hagerstown-Washington-Md.

24. FUNERAL DIRECTOR: Wm. E. Horst

ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.

25a REC'D BY REGISTRAR DATE: JUL 31 1967

25b REGISTRAR'S SIGNATURE:

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10227

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10225

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY: WASHINGTON — MARYLAND	2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a STATE: MARYLAND b COUNTY: WASHINGTON
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HAGERSTOWN — c LENGTH OF STAY IN Tb: 57 YEARS	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HAGERSTOWN
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): WESTERN MARYLAND STATE HOSPITAL	d. STREET ADDRESS: 35 EAST AVENUE — e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print) First: MAE Middle: HAINES Last: WEMPE	4 DATE OF DEATH Month: JULY Day: 15, Year: 19 67
5 SEX: FEMALE — 6 COLOR OR RACE: WHITE — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8 DATE OF BIRTH: MAY 16, 1885 — 9 AGE (In years last birthday): 82 yrs — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER — 10b KIND OF BUSINESS OR INDUSTRY: OWN HOME — 11 BIRTHPLACE (State or foreign country): LURAY, VIRGINIA. — 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: HAINES — 14. MOTHER'S MAIDEN NAME:	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO — (If yes give war or dates of service): **** — 16. SOCIAL SECURITY NO: — 17 INFORMANT: MR. MARTIN E. WEMPE, Address: 911 FREDERICK STREET, HAGERSTOWN, MARYLAND.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic Cardio Vascular Disease — Several years

DUE TO

(c) Fracture Hip — 63 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 of item 18.): Fell in her home.

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 5-12- 19 67 — 20d INJURY OCCURRED While at work ☐ Not While at work ☒ — 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home — 20f (City or town, county, State): Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above held on Autopsy ☐, Inspection ☒, Inquiry ☐ and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D

EXAMINER'S NAME (Type): E. W. DITTO, JR.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 215 W. WASH. HAGERSTOWN, MARYLAND.

22. DATE SIGNED: JULY 17, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 7/18/67 — 23c NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY — 23d LOCATION (City, town, county, State): HAGERSTOWN, WASH. CO. MD.

24 FUNERAL DIRECTOR: CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. — ADDRESS — 25a RECEIVED BY REGISTRAR DATE: JUL 19 1967 — SIGNATURE: Charles Rouzer Judge

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10223

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maugansville
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 412 N. Main St.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maugansville
d. STREET ADDRESS: 412 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Maud — Middle: Alice — Last: Willey

4. DATE OF DEATH: Month: July — Day: 10, — Year: 19 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-11-1886

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): teacher

10b. KIND OF BUSINESS OR INDUSTRY: college

11. BIRTHPLACE (State or foreign country): Mead, Nebr.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jay Willey

14. MOTHER'S MAIDEN NAME: Elizabeth Gilchrist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address: Mrs. Cliff Zicafoose, Mead, Nebr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4200
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Several years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): 2nd. & 3rd. degree burns of chest, shoulders
DUE TO
(c): & face. — Several hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Patient fell from commode on to small electric heater.

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: 7-10- 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Maugansville, Washington, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Dr. E. W. Ditto Jr. M.D

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 7-14-67

Address (Street, city, town or county): Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 7-17-67
23c. NAME OF CEMETERY OR CREMATORY: Sunrise Cemetery
23d. LOCATION (City or Town) (County) (State): Wahoo, Nebr.

24. FUNERAL DIRECTOR: Minnich Funeral Home, Hagerstown, Md.

25a. RECD BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10229 10227

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown c. LENGTH OF STAY IN 1b: D.O.A.	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg rural d. STREET ADDRESS: Foxville e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital	

3. NAME OF DECEASED (Type or print): First: Sadie	Middle: Marie	Last: Wolfe	4. DATE OF DEATH: Month: July	Day: 4	Year: 19 67		
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 2-4-1900	9. AGE (In years last birthday): 67 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (County & State, or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME: Lewis Smith	14. MOTHER'S MAIDEN NAME: Emaline Comfort						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 219-20-1757	17. INFORMANT: Elaine Baker	Address: Smithsburg, Md. RD 1				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): arteriosclerotic heart disease — UNKNOWN
DUE TO (c): Generalized arteriosclerosis — UNKNOWN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 5-14, 19 67, to 6-[illegible], 19 67, that (I) (we) last saw the deceased alive on 6-[illegible] 19 67, and that death occurred at 7:44 P.M., from causes and on the date stated above.

22a. SIGNATURE: E. R. Lardizabal M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 7-3-1967	
22c. PHYSICIAN'S NAME (Type): E. R. Lardizabal, M. D.	22d. ADDRESS: 300 North Potomac St. Hagerstown, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 7-7-67	23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah Cemetery	23d. LOCATION (City or Town) (County) (State): Foxville Fred. Co. Md.	
24. FUNERAL DIRECTOR: Raymond E. Creager	ADDRESS: Thurmont, Md.	25a. REC'D BY REGISTRAR DATE: JUL 10 1967	25b. REGISTRAR'S SIGNATURE: Charles Zinn	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10230

CERTIFICATE OF DEATH

10228

1. PLACE OF DEATH
a. COUNTY: Washington
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: --
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 837 Virginia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Premature Middle: Baby Boy of Joseph J. Lost: Young

4. DATE OF DEATH: Month: July Day: 28 Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 28.1967
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours 2 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md. Wash. Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph J. Young
14. MOTHER'S MAIDEN NAME: Linda Sipes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Joseph J. Young Address: 837 Va. Ave Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity (Ill-defined) 7625
DUE TO
(b): Unspecified cause
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2hr 15min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/25, 1967, to 7/28, 1967, that (I) (~~we~~) last saw the deceased alive on 7/28 1967, and that death occurred at 9:20 AM, from causes and on the date stated above.

22a. SIGNATURE: A. M. Bacon Jr M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): A. M. Bacon Jr M.D.
22d. ADDRESS: 101 King St Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 29/67
23c. NAME OF CEMETERY OR CREMATORY: Manor Cemetery
23d. LOCATION (City or Town) (County) Md (State): near Tilghmanton Wash Co

24. FUNERAL DIRECTOR: Hagerstown Md.
ADDRESS: Andrew K. Coffman Funeral Home Inc

25a. REC'D BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

7-25-7625